SUMMARY REPORT:

USAID SUPPORT FOR FAMILY PLANNING/ REPRODUCTIVE HEALTH IN BRAZIL

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by

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LIST of ACRONYMS

ACHE	Ache Laboratórios Farmaceuticos, S.A.
ABEPF	Brazilian Association of Family Planning Organizations
AIDS	Acquired Immune Deficiency Syndrome
AIDSCOM	AIDS Communication program, USAID-funded CA
AIDSTECH	AIDS Technical Assistance Project, USAID-funded CA
AVSC	Association for Voluntary and Safe Contraception
BEMFAM	Sociedade Civil Bem-Estar Familiar no Brasil (Local IPPF Affiliate)
CA	Cooperating Agency
CFEMEA	Centro Feminista de Estudos e Assessoria
CEPEO	Importãçao e Comércio de Insumos Farmaceuticos Ltda. (Commodity Procurement Organization)
CIDA	Canadian International Development Agency
CMS	Commercial Market Strategies
COPE	Client-Oriented, Provider-Efficient Services of AVSC
CPAIMC	Centro de Pesquisas de Assistencia a Mulher e a Criança
DFID	Department for International Development (United Kingdom)
DHS	Demographic and Health Survey
DKT	Digitagle Kommunications Technik
EC	Emergency Contraception
FEBRASGO	Brazilian Federation of Societies of Obstetrics and Gynecology
FHI	Family Health International
FHPIPSF	Government of Brazil's Family Health Program/Programa de Saude da Familia
FP/RH	Family Planning/Reproductive Health
FPMD	Family Planning Management Development Project
FSN	Foreign Service National
GNP	Gross National Product
GOB	Government of Brazil
HIV	Human Immunodeficiency Virus
HMO	Health Maintenance Organization
IDB	Inter-American Development Bank
ICPD	International Conference on Population and Development
IEC/BCC	Information, Education, Communication/ Behavior Change Communications
IUD	Intrauterine Device
JHPIEGO	Johns Hopkins Program for International Training in Reproductive Health
JHU/PCS	Johns Hopkins University Population Communication Services
JICA	Japanese International Cooperation Agency
LAC	Latin American and Caribbean region of the U.S. Agency for International Development
MEASURE	Monitoring and Evaluation to Assess and Use Results, USAID-funded CA
MIS	Management Information System

MOH	Ministry of Health
MSH	Management Sciences for Health
NGO	Non-Governmental Organization
OPTIONS	Options for Population Policy, AID-funded CA
PAISM	Programa de Assistencia Integral a Saude da Mulher
PHC	Primary Health Care
PHN	Population, Health, and Nutrition
PNMR	Perinatal Mortality Rate
POMMAR	Prevenção Orientada a Meninos e Meninas em Situacao de Risco – USAID/Brazil-financed At-risk Youth Program
PROFIT	Promoting Financial Investments and Transfers, USAID-funded CA
PROJOVEN	BEMFAM youth program
PROPATER	Promoção da Paternidade Responsavel
PROQUALI	Quality and Performance Improvement Project under USAID RH Program
RAPID	Resources for Awareness of Population Impacts on Development- USAID-funded CA
REFORSUS	Reforço do Sistema Unico da Saude (Reform of the GOB Unified Health System)
SESA/CE	Secretaria da Saude do Estado de Ceará
SESAB	Secretaria da Saude do Estado da Bahia
SISMAC	Management Information System used in Bahia
SOMARC	Social Marketing for Change, USAID-funded CA
STD	Sexually-Transmitted Diseases
SUS	Sistema Unico de Saude
TOQUES	Tecnica para Orientar a Qualidade e Eficiencia dos Servicos de Saude
UNFPA	United Nations Population Fund
UNICEF	United Nations Childrens Fund
UNIMED	Brazilian Health Maintenance Organization
USAID	United States Agency for International Development
USAID/Brazil	The Brazil Mission of USAID
USAID/W	The Washington headquarters of USAID
WHO/HRP	World Health Organization/Special Program in Human Reproduction

EXECUTIVE SUMMARY

USAID support for family planning and reproductive health (FP/RH) in Brazil continued for more than thirty years, from the late 1960s until the program was officially closed in September 2000. USAID was the pioneer donor in providing family planning assistance in Brazil and, remarkably, remained the largest donor until 2000. USAID family planning assistance to Brazil can be divided usefully into three phases: Phase I from the late 1960s until 1988; a transition period from 1989 until early 1992; and Phase II from mid-1992 until program phase-out in September 2000. Funding levels throughout the period were between $5-8 million per year.

While this report provides a summary of USAID assistance prior to 1992, it concentrates on the achievements of the Phase II program implemented between 1992-2000. A new strategy for USAID family planning assistance to Brazil, designed in July 1992, noted that the high overall contraceptive prevalence among married women in Brazil (66 percent in 1986) masked disturbing realities. Almost 80 percent of contraceptive users relied on only two methods -- female sterilization and oral contraceptives. In the Northeast, which lagged behind the rest of the country, the use of oral contraceptives was declining, and there was a growing reliance on female sterilization (and, although not measured in the Demographic Health Survey (DHS), abortion).[1] Therefore, the new (and final) USAID strategy would focus on improving the quality of family planning programs for poorly served populations in the Northeast. Quality would be enhanced by expanding the choice of methods broadly available to women, improving counseling, and making better information available to clients for contraceptive choice and proper method use.

The new strategy's second objective was "to promote the sustainability of family planning in appropriate delivery systems."[2] This strategy focused much less on non-governmental organizations (NGOs) than in previous years, and worked directly with state health systems in two large Northeastern states, Bahia and Ceará, where needs were obvious and there was a clear desire to improve existing state health services. The program gave a new priority to working with large-scale health maintenance organizations (HMOs), third-party insurance, and group medicine plans to encourage inclusion of family planning in their basic health plans. The new strategy recognized that family planning services needed to be provided within the context of Brazilian service delivery systems which focused broadly on reproductive health, women's health, and family health. Efforts were made to work more closely with the influential Brazilian women's movement in order to encourage stronger and better-financed government health programs. The strategy also attempted to ensure integration with new USAID programs focusing on HIV/AIDS and at-risk youth, and to encourage other donors to finance reproductive health programs in Brazil.

In 1995, a mid-term strategy evaluation concluded that the decision to focus assistance "on a few issues (quality of services, sustainability, private/public roles), a few activities to address those issues (training; information, education, communications (IEC); commodities; investment in for-profit activities; and research/evaluation), and in two states of Brazil's poorer Northeastern

[1] "Strategy for USAID Assistance in Family Planning to Brazil, 1992-2000". July 1992.

[2] Ibid, p. 15.

region was a sound one."[3] Given the short phase-out period remaining, its major recommendations included a new "management" component in the two state program, and to avoid any new private sector ventures (after the failure of UNIMED, a Brazilian-HMO's pilot activity).[4]

Program Achievements

The Phase II USAID family planning program clearly has contributed to the improvement of family planning quality and services in Brazil since 1992, and has produced a number of very significant achievements, some of which warrant replication throughout the country. Program failures and disappointments are relatively few, according to almost all observers. Because the program strategy included a mix of national/regional, state level, and qualitative activities, the program achievements and program contributions are summarized within that three-tiered framework.

The USAID family planning program in Brazil was one of three USAID-funded programs that, to at least some degree, fell conceptually within the broader definition of the Government of Brazil's (GOB) Family Health Program, and the broader agenda of the 1994 International Conference on Population and Development (ICPD) held in Cairo, Egypt. Therefore, the important linkages between the family planning program, the HIV/AIDS program, and the Prevenção Orientada a Meninos e Meninas em Situacao de Risco (POMMAR), a USAID/Brazil-financed At Risk Youth program are discussed in the body of the report.

National and Regional Level Initiatives

The Policy Setting. The overall policy environment for FP/RH in Brazil is much more open and supportive today than in 1992, thanks largely to the new vision of population and reproductive health that emerged from the ICPD. Brazilian women's health advocates, whose participation at the "Cairo Conference" was financed partly by USAID, were major players in the ICPD process and helped forge the resulting client-focused reproductive health approach to family planning and other family health issues. Despite some resistance from the Catholic Church, there is now clear Brazilian government support for FP/RH including a national policy on population and FP/RH rights. USAID played a valuable role by urging its Cooperating Agencies (CAs), and the Brazilian entities supported by the CAs, to adapt to the changes brought by Cairo, and by encouraging dialogue among the protagonists.

After Cairo, national women's groups and others took the lead in the development of a national policy on population and FP/RH rights, including legislative action to establish regulations for surgical sterilization and other aspects of fertility regulation. USAID-funded CAs supported these efforts in important ways by providing technical guidance on the establishment of national reproductive health norms and guidelines and by helping to overcome regulatory obstacles such as tariff barriers and cumbersome condom testing procedures.

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[3] "Assessment of USAID/Brazil Population Assistance Strategy" p. 8. POPTECH Report 95-037-030, 1995.

[4] This pilot project was to establish an outreach clinic for lower income beneficiaries, and include family planning benefits in its package.

Support for Research and Data Development. This is a "headline" achievement of the program. USAID's pioneering support for research and data development played a highly significant role in building up the evidence base for policy and program development for population and reproductive health in Brazil both before and during the Phase II period. Sociedade Civil Bem-Estar Familiar no Brasil (BEMFAM), with CA assistance, supported two national-level DHS surveys (1986 and 1996), as well as a Northeast Regional Survey in 1991. These surveys contributed enormously to the awareness of population and reproductive health issues and were the basis for new program design and evaluation by government entities and donors. Brazilian technical capacity to undertake DHS surveys is now assured and BEMFAM is initiating another national survey with financing from the Ministry of Health (MOH) using World Bank (IBRD) loan funds.

In addition, the Population Council's operational research program implemented baseline and follow-up situational analyses on service delivery issues in Bahia and Ceará, as well as research to support the introduction of contraceptive methods, improved quality of service delivery, and community participation in program management. These initiatives also contributed to the development of a national capacity to continue working with this methodology.

Increased Choice of Contraceptive Method. One of the major programmatic concerns at the time the Phase II strategy was designed was the narrow range of fertility regulation options available to Brazilian women. As a result, efforts to broaden contraceptive choice were undertaken.

At the national level, USAID CAs contributed through research, training, and regulatory work on the introduction of new methods, and the reintroduction of the intrauterine device (IUD) which was under-utilized. A series of workshops on contraceptive technology led to the MOH incorporation of emergency contraception (EC) into the public sector program. CAs worked with a Brazilian pharmaceutical company to arrange an agreement for registration and commercialization of a dedicated EC product. CAs supported research on the acceptability of clinical performance of the female condom and introduced the "Reality" female condom to Brazil. The Population Council conducted research on the levonorgestrel-releasing IUD, and on diaphragms used continuously without spermicide or before intercourse with spermacide.

Private sector and contraceptive social marketing initiatives contributed to an expanded range of method choice through partnerships with pharmaceutical companies for introducing and marketing injectables (Depo-Provera and Triciclon). BEMFAM's new PROSEX condom and Digitagle Kommunications Technik's (DKT) condoms, the latter provided under the USAID-supported HIV/AIDS program, now make up 16 percent of the growing Brazilian condom market.

While these efforts laid the groundwork for an expanded choice of methods, substantial barriers to the expanded use of methods remain for both the providers and users. The 1996 DHS showed little change in the heavy dependence on surgical sterilization, but definitive conclusions about more recent changes in Brazil's contraceptive methods mix must await the results of the 2001 DHS.

A major strategic question in 1992 was, "How will contraceptives be provided to public sector clinics when the USAID program is completed?" The answer is much clearer, at least for the short-term, than might have been expected. Bahia and a few other states and municipalities have begun to purchase contraceptives for their public health facilities. The MOH is procuring large quantities of pills, injectables, IUDs, and diaphragms for the first time for nation-wide distribution to public facilities, and plans to provide contraceptive methods for at least three years (condoms are provided via the MOH's HIV/AIDS program). BEMFAM continues to supply methods to about 1,000 municipalities through its *convenios* (agreements), methods that are now purchased on the open market rather than donated.

Despite improvements, longer-term prospects for method availability remain somewhat problematic. The three-year MOH supply is described as "transitional" and not permanent. With decentralization, municipalities will eventually be responsible for procurement. Methods are not yet included in the basic medicines package available to municipalities, though some states, such as Ceará, have recently modified the content of their basic medicines list at the state level to include oral contraceptives.

Private Sector Initiatives. Efforts to encourage the commercial private sector to provide family planning services and to sell a variety of contraceptives at reasonable prices have had mixed results. While a pilot effort to encourage a large HMO (UNIMED) to include family planning in its benefit package failed, a more successful venture was the creation of a profitable private contraceptive supply company, Importãçao e Comércio de Insumos Farmaceuticos Ltda. (CEPEO), that sells imported IUDs at very modest prices along with diaphrams, the female condom, and a growing range of other reproductive health-related products including educational and training material.

Although the Phase II strategy achieved less in the private-sector arena than might have been desirable, the contributions are nonetheless valuable. Technical support to BEMFAM's condom initiative was a critical element in the turnaround of BEMFAM's sustainability prospects. Partnerships with major pharmaceutical companies demonstrated that it is possible to attract the industry's interest to socially important initiatives such as the introduction of EC, and to reduce the sales price of other new methods, such as injectables.

After a slow start, Phase II efforts to ensure the financial sustainability of BEMFAM appear to be successful. BEMFAM indicates that by end of the year 2000 it will be 91 percent financially sustainable due to: a) growing sales of its new PROSEX condom; b) diversification of services and more realistic pricing of its *convenios* with municipalities; c) improved internal cost controls and profitability of its clinic laboratories; d) diversification into other areas of reproductive health (HIV/AIDS, cervical cancer screening, adolescent programs); and e) a wider array of funding sources. Moreover, BEMFAM has adopted the ICPD Program of Action, is on much better terms with women's groups and the MOH, and is playing a national advocacy role on reproductive health issues.

Qualitative Initiatives

PROQUALI. In 1996, three CAs and state leaders in Bahia and Ceará developed a strategic approach and tool kit for continuous quality improvement in FP/RH. The process, which led to an innovative and effective "product" named PROQUALI, was motivated, in part, by the need to address quality of care in a coherent, systematic, and locally applicable way.

PROQUALI is a client-focused model aimed at attaining a sustainable system for quality reproductive health services at the clinic level; the scope embraces the full range of basic reproductive health services. PROQUALI uses the Association for Voluntary and Safe Contraception (AVSC) quality assessment tool (COPE) in addition to management and provider training. Accreditation has been added as a central element. The systematic approach to self-evaluation and client interviews has created a strong sense of ownership and self-determination among service provider staff at the health posts to meet the criteria for program accreditation. This has proven very effective in mobilizing local commitment and resources. Interventions have included development of generic standards for reproductive health care along with quality criteria including such considerations as waiting time, hygiene, and client access to information material, managerial and leadership training, team building exercises, and in-service training of staff in essential reproductive health care.

In the initial pilot phase, it quickly became clear that it would not be possible to limit quality improvements in a health facility uniquely to family planning services and, thus, the scope of PROQUALI embraces the full range of basic reproductive health. The Bahia and Ceará state health secretariats regard PROQUALI as a quality initiative that fits well with both their Family Health Care programs and municipalization.[5]

PROQUALI is an attractive model for improving primary health care services in municipalization and Family Health Care programs through a client-centered approach, involving all staff in an effective and participatory way. It has created much interest outside the FP/RH field, both in Bahia and Ceará states, and elsewhere in Brazil. Despite its promise, implementation of PROQUALI is still in its initial stages, and it will need wider execution to realize its full potential and take its final shape.

Behavior and Communication Change (BCC). The IEC/BCC materials developed for the PROQUALI communications campaign with the slogan "Mulher é pra se cuidar"(Women are worth caring for and worth caring for themselves) comprise an unusually well-conceived integrated package of materials to promote FP/RH. To a large extent, this key message, and the material and messages around it, reflects local implementation of the ICPD Program of Action.

The communication strategy is now reflected both in media messages, in brochures and leaflets for clients, and in training/criteria for communication with clients. With modest adaptations, the

[5] A decentralization process that transfers government responsibilities and funding to the "county" level in Brazil's federal system - that, similar to the United States, also includes federal and state level responsibilities and funding.

materials also can be used for other reproductive health programs that are not PROQUALI-specific.

SISMAC. Another significant improvement during Phase II of USAID assistance was the development, by Pathfinder, of a multi-purpose management information system (MIS) for reproductive health named SISMAC. In Bahia, the necessary hardware, software, and training have been provided throughout the state. The SISMAC software program allows the state health secretariat to receive monthly data on commodity logistics, service provision, and training in municipalities. The data are used for program monitoring, management decision-making, and future planning. Although the system presently is used only for women's health programs, it can be expanded for broader health system use. In early 2000, the MOH requested that Pathfinder and SESAB adapt the SISMAC software to monitor the flow of contraceptives that the MOH plans to distribute throughout Brazil, to provide logistics training for personnel involved in contraceptive management, and to assist in improving warehouse practices.

State Initiatives

During Phase II, USAID support focused on state-level programs for the first time, specifically in the Northeastern states of Bahia (12.5 million inhabitants) and Ceará (7 million inhabitants). Both states are among the poorest of the 27 states in Brazil, and have similarly poor health indicators.

Bahia. During the early 1990s, the USAID-funded family planning program contributed to the expanded provision of family planning to over 50 percent of the State's municipalities, increased numbers of state and municipal health personnel trained in family planning, and improved logistic management and the provision of commodities. Bahia became one of the first states to purchase contraceptives in 1995 and then successfully engaged municipalities in sharing the costs of contraceptives, spending over $1.7 million by 1999. A comprehensive management information system (SISMAC) is now being used throughout the state to provide data on service delivery, contraceptive needs, and overall program management.

While service expanded rapidly in Bahia, improvements in quality appear more modest, although little recent data are available. According to Situational Analysis data, the percentage of service sites with all appropriate methods on hand (oral contraceptives, IUDs, and condoms) increased in the first four years of the program from 21 to 26 percent. The percentage of service sites with health providers trained, adequate equipment, available contraceptive commodities, and consumable supplies increased from 6 to 16 percent. Fifty-three percent of clients interviewed at random when exiting service sites stated that they had perceived a positive change in the quality of care.[6]

From 1996 onwards, design and pilot implementation of the Quality Improvement Project (PROQUALI) was a major state focus. Statewide management training, training of master Client-Oriented, Provider-Efficient Services (COPE) facilitators, definition of quality service

[6] "Final Report for USAID: Family Planning/Reproductive Health". The Population Council, February 2000., p. 16-17.

delivery criteria based on state guidelines, training of providers, communication activities to generate demand for and promote quality service, and the training and establishment of a PROQUALI Accreditation Committee were major accomplishments during this period. While highly praised for its quality improvements and desired as a model by various states, the PROQUALI program has been fully implemented only in two pilot health posts and presently is being expanded to a second set of ten health posts. With USAID's departure, a means to support the continued expansion within Bahia of the very promising PROQUALI program will have to be found.

Ceará pioneered the "Viva Criança" program in the 1980s that led to the new federal government Family Health Program (FHP) in 1994, with family health teams and community health agents covering their specific geographical areas. Ceará benefited from United Nations Population Fund (UNFPA) program support for a follow-on "Viva Mulher" program between 1994 and 1999, with funds used primarily to properly equip reproductive health units at health posts, to purchase contraceptives, and to train supervisors. USAID support in Ceará complemented UNFPA assistance by focusing on program strategy, management training, provider training (including at the largest medical school), development of a contraceptive logistics management system, a leadership development program, and the development of IEC programs and materials.

In Ceará, implementation of FP/RH overall has been somewhat slower than in Bahia. However, it has been integrated into the primary health care system in a solid and sustainable fashion. Family planning services in Ceará improved modestly during the 1990s. The number of service sites providing family planning services increased from 512 in 1992 to 532 in 1999. Qualitative data is less recent and available only until 1997. The percentage of sites with all methods on-hand remained stable at 11 percent, between 1993 and 1997. The availability of most contraceptives on-site increased significantly, except for condoms. However, great improvement was noted in all other areas of preparedness since nearly all facilities had all other components (trained provider, equipment, and consumable supplies). Of clients interviewed, 53 percent perceived a quality improvement.[7]

As in Bahia, the PROQUALI initiative was begun in 1996, about midway through the Phase II period. PROQUALI was fully implemented in two facilities in the pilot phase (1996-98)[8], and is being expanded to 14 health facilities in nine municipalities (one micro-region and Fortaleza) in the initial expansion phase (1998-2000). The state hopes to expand the program to five more micro-regions (there are twenty-one in Ceará) between 2000 and 2002, but, from the state health department perspective, it will need additional donor support to consolidate the program and continue its expansion throughout Ceará.

The results of USAID support for these two states are highly positive. Although the states are quite different in many ways, they demonstrate how the PROQUALI model can be implemented successfully in states with different state health structures, varying degrees of municipalization, and quite different leadership characteristics. Potential donors for PROQUALI replication

[7] Ibid., p. 16-17.

[8] The program was started in three facilities but one dropped out.

appear to have more confidence in the program since it has been tested successfully in two very different settings.

Areas of Concern

As summarized above, the Phase II program had very significant achievements during the decade of the 1990s, and there have been simultaneous improvements of reproductive health quality and sustainability throughout Brazil during the same period. As one looks to the future, there are several areas of concern that are discussed in the full body of this report. They are:

- the effective integration of family planning successes within reproductive health and family health initiatives, and as part of Brazil's ongoing health sector reform;
- the sustainability of the PROQUALI pilot program in Bahia and Ceará without USAID support;
- the need for reproductive health services for adolescents and other underserved groups; and
- the inadequate provision of adequate post-abortion family planning information as part of reproductive health programs.

Program Elements that Should be Replicated or Sustained and Opportunities for Future Investments in Brazil's Reproductive Health Programs

***Priorities for replication*:** Several key program elements are "proven" and should be replicated beyond their present geographical limits:

a) PROQUALI is an excellent model that is ready for replication beyond Bahia and Ceará. Two neighboring states already have indicated considerable interest in adopting this program and PROQUALI would be a valuable addition to the MOH's Family Health Program initiative. The expansion of PROQUALI within Bahia and Ceará also will require some outside support;

b) The SISMAC management and logistics information system is an excellent integrated MIS that is functioning satisfactorily in Bahia, one of Brazil's largest and most rural states. Although one element of the SISMAC system, the logistics management module, is being adopted by the MOH for planning the need for and monitoring of contraceptives, the broader integrated system should be considered for use by Brazilian state health services;

c) The stocks of IEC/BCC materials developed for the PROQUALI initiative are already running low in Bahia and Ceará, and much greater quantities of these excellent materials would be needed for PROQUALI program expansion in other states. With modest adaptations, the materials also can be used for other reproductive health programs that are not PROQUALI-specific; and

d) BEMFAM's *convenio* support for reproductive health delivery systems in underserved states is a proven service delivery system that continues to be "in demand" and paid for by municipalities in almost all Northeastern states. BEMFAM convenio services probably would be extremely valuable in the underserved states of the North and Central West regions (especially the more remote states). However, BEMFAM would need an infusion of outside funds to expand its (newly self-sufficient) program to any new states.

***Priorities for Sustainability*.** At least two key program areas appear to require future attention to ensure their sustainability:

a) DHS and other related demographic research and data development. Although BEMFAM now has the research skills and analytical experience to lead future DHS surveys in Brazil, BEMFAM does not have the resources to finance these surveys which should be funded by the MOH, and/or by donors and foundations at periodic five-year intervals; and

b) Operational research on new and existing contraceptive methods has been carried out in Brazil with the leadership and support of the Population Council. While the Population Council intends to retain its office and continue its operations in Brazil, donor and/or foundation support certainly will be welcomed for new research initiatives.

1.0. BRAZIL COUNTRY SETTING

1.1. Economic and Demographic Context

Brazil is an upper-middle income country that has virtually completed its transition to low levels of fertility, mortality, and population growth. The population, approximately 168 million, is close to one-third of the total population of the Latin America/Caribbean (LAC) region. Brazil's $4,600 per capita gross national product (GNP) is slightly lower than the average for upper-middle income countries, but higher than average for the LAC region. In spite of its relatively high-income level, Brazil lags behind other countries in the region in key social indicators including infant, child, and maternal mortality, access to safe water, and income distribution. In part, this reflects Brazil's regional diversity, but it is also a dimension of the gap between the rich and the poor in its many large cities. Brazil is highly urbanized, with approximately 80 percent of its population residing in urban areas. A substantial proportion of that figure is located in the major metropolitan areas in the more industrialized South-central region (São Paulo, Rio de Janeiro and Belo Horizonte). Recent decades also have brought rapid growth in metropolitan areas in the Northeast, including Salvador, Recife and Fortaleza.

Brazil's economy experienced rapid growth during the 1960s and 1970s, when double-digit annual growth rates were recorded, and the structure of the economy underwent rapid change. A series of setbacks, including the debt crisis, increased oil prices, and a fall-off in foreign credit resulted in a period of poor economic performance that started during the early 1980s and ended only in the mid-1990s with the changes in economic policy associated with the *Plan Real*. The *Plan Real* brought inflation under control through a series of stringent restraints on exchange rates, and abandonment of the long-standing policy of indexing credit instruments.

The period from the early 1960s to the late 1990s witnessed rapid demographic changes in Brazil. The population growth rate, which was around three percent per annum in the 1960s, dropped to 1.3 percent in the 1990s. The total fertility rate declined from around six births per woman of reproductive age to less than 2.5, while contraceptive prevalence increased from approximately 10 percent to 75 percent.

National averages have masked wide regional disparities in economic and demographic conditions. Income per capita in the richest state (São Paulo) is seven times the income per capita in the poorest state (Piaui). About 33 percent of the population in the poorer Northeastern region is in poverty, compared to 11 percent in the better-off Southeast. The demographic transition was underway as early as the 1960s in the more prosperous urban centers of the Southeast, whereas it was not until the 1980s that the process took hold in the poorer areas of the North and Northeast. Even now, large areas of the rural North lag far behind the rest of the country in key indicators. For example, women without education in the Northeast report that they had 2.3 more children than desired. This is significantly higher than the level of undesired children reported for Brazil as a whole (0.7).[1]

[1] IBRD internal report.

1.2. Changes in Brazil's Health System

The political opening that occurred with the return of civilian government during the 1980s marked the start of a major restructuring of Brazil's health care system. The Constitution of 1988 guaranteed free essential health care to all members of the population, an entitlement that the existing health system was clearly failing to deliver. To achieve greater equity and efficiency in the allocation of its health resources, the Government of Brazil (GOB) embarked on a series of bold health reform measures under the aegis of its Unified Health System (SUS). Even before SUS, Brazil's health system was characterized by substantial private service provision, financed through the country's national social insurance scheme (and various subsidiary schemes for public employees and other designated groups). However, the structure of this system was such that the urban middle and upper classes were the main beneficiaries, and the bulk of resources went to more expensive curative care at the secondary and tertiary service levels.

SUS dismantled its social security health delivery system in the late 1980s, turning its staff and facilities over to municipalities and promising financial support to municipalities through a revenue-sharing scheme. Unfortunately, the launching of this plan coincided with rapidly deteriorating macroeconomic and fiscal conditions in the country, and many municipalities found that they were saddled with large recurrent burdens for salaries, medicines, and the upkeep of facilities, but with little income to pay for them. As "municipalization"[2] pushed ahead, middle- and upper-income groups fled to private insurance plans, although they continued to rely on the SUS system for emergency care, further undermining the effort to reallocate resources to primary care and to benefit the poorer segments of the population. Assessments of the first decade of the SUS experience suggest that the poor are less well-served and spend higher out-of-pocket amounts on health care and medicines than before SUS was launched.[3]

Since 1994, Brazil has been revamping the SUS model ("reform of the reform"), with expanded attention to primary care. The Ministry of Health (MOH) launched a Family Health Program (FHP) aimed at revitalizing primary care and making it responsive to the health needs of lower income groups. Each municipality is allocated R$10[4] per capita for its health post to offer simple procedures, including general medicine, oral health, well baby exams, family planning and vaccinations. These services are provided by health teams (a doctor, nurse, and nurse's aide) working in tandem with community health agents. The state of Ceará pioneered this approach, and the Government plans to expand it to cover half the country's population by 2002. A large World Bank loan is being proposed to finance the program.

1.3. Reproductive Health and Family Planning in Brazil

Family planning services in Brazil evolved along a quite different path than one finds in countries with organized national programs. Of the two main methods that prevail, the primary

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[2] A decentralization process that transfers government responsibilities and funding to the "county" level in Brazil's federal system - that, similar to the United States, also includes federal and state level responsibilities and funding.

[3] Medici, André Cesar, "Uma Década de SUS (1988-98): Progressos e Desafios, pp. 104-150 in Loren Galvão & Joan Díaz, Saúde Sexual e Reproductiva no Brasil, São Paulo, Editora Hucitec/Population Council, 1999.

[4] Approximately US$6 in 2000.

source for the oral contraceptive pill has been private pharmacies. Until passage of the 1997 family planning law, tubal ligations were generally provided sub-rosa in conjunction with caesarian-section deliveries by private physicians, with reimbursement by the public sector – first the social security system, and later the SUS. Private non-governmental organizations (NGOs) played a key role in training physicians and promoting the acceptability of planning family size, but their direct impact on overall service delivery was limited. As will be seen below, two of them (Sociedade Civil Bem-Estar Familiar no Brazil (BEMFAM) and Pathfinder) grew to play an important role in the distribution of donated contraceptives to municipal governments.

Consumer demand for family planning expanded rapidly during the 1970s and 1980s. Analysts cite a number of factors that may have contributed to the fast-growing desire to limit family size during that period. In addition to the effects of the overall rapid structural change in the Brazilian economy -- including swift urban and metropolitan growth, increased education, and changes in women's roles -- other forces have been recognized such as increased exposure, by all segments of the population, to mass media, and the influence of the medical community in facilitating the rapidly expanding prevalence of tubal ligations. Another set of forces, which may have contributed to the spread of family limitation to lower-income regions and population groups during the 1980s, were pressures on household budgets caused by the worsening economic conditions during that decade.

Concerns about distortions in the way in which the expansion of family planning in Brazil was occurring led women's health activists to promote a comprehensive approach to reproductive health at the time that the country was returning to civilian government. The Programa de Assistencia Integral a Saude da Mulher (PAISM) incorporated nearly all of the elements of reproductive health care that were called for a decade later in the 1994 International Conference on Population and Development (ICPD), a fact that has led many national observers to note that the ICPD simply ratified a set of changes that were already underway in Brazil.

The political and economic turmoil of the late 1980s and early 1990s, and opposition from the Catholic Church prevented the government from moving ahead with implementation of the PAISM program. The year 1994 was pivotal in bringing economic stability and an opportunity for the new government to commit itself to the implementation of a family health service package that incorporated the PAISM model. Since then, reproductive health care has been increasingly integrated in municipal-level primary care services. Interventions, such as prenatal and maternity care, have improved, and the prevention/treatment of sexually transmitted diseases are better integrated with family planning/reproductive health (FP/RH) services. The Government also has responded to the HIV/AIDS epidemic with a well-managed national program, though one that has recently focused much of its financial expenditures on the treatment of a portion of the HIV-infected population rather than prevention.

While the overall picture is definitely more positive than in the early 1990s, many challenges remain. Health care financing is problematic, and municipalization has created new problems in maintaining political support and a commitment to the implementation of the new program. Despite recognition of a need to improve the quality of services, consumers continue to be poorly

treated in the public health system, and inequities in access and distortions persist in the allocation of public resources toward services that benefit higher-income users.[5]

1.4. Purpose of this Report

The purpose of this report is to provide a summary of USAID assistance for FP/RH programs in Brazil prior to 1992 (as more detail on this period is available elsewhere), and to concentrate on the accomplishments of the Phase II program between 1992-2000 (Annex A Scope of Work). The report discusses the program's achievements, and focuses on the future by highlighting components of the program that either merit replication elsewhere or continued support by GOB entities and other donors. This report does not follow the model of some previous "close-out" reports of USAID family planning programs (Turkey, Mexico, Colombia). Likewise, this document does not attempt to provide a comprehensive, all-inclusive review of program objectives and results. Rather, it draws on the final reports of the Cooperating Agencies (CAs) that have worked in Brazil with USAID funding (Annex B), and benefits from interviews with key Brazilian and American interlocutors.

1.5. Team Members

POPTECH was asked to provide a three-person Team consisting of:

John Pielemeier, Team Leader;
Tom Merrick, Demographer and FP/RH Specialist; and
Jerker Liljestrand, RH Specialist.

1.6. Schedule and Methodology

The Team visited Brazil for three weeks in March/April 2000. They attended a meeting of CAs in Salvador, Bahia, on March 27, 2000, and visited several project sites during their stay. The Team:

- reviewed and analyzed findings, recommendations, research results and analysis from several studies on the Brazilian program including final reports from each of the CAs and key local partners (Annex C);

- consulted with USAID/Washington and USAID/Brazil staff;

- interviewed policy makers and program managers in the public and private sectors;

- consulted with other donors, as well as staff from USAID projects and state government projects; and

[5] Almeida, Celia et. al. "Health Sector Reform in Brazil: A Case Study of Inequality". International Journal of Health Services. Vol 30, No. 1, 2000.

- visited FP/RH programs of the public and NGO sectors in the states of Bahia and Ceará. During the field visits, the Team interviewed program managers, service delivery personnel, public health care officials, and local community leaders.

For a list of persons interviewed please refer to Annex D.

2.0. ROLE OF USAID

USAID has provided family planning assistance to Brazil since the late 1960s. This brief summary of that assistance divides USAID programs into three phases: Phase I from the late 1960s until 1988, a transition period from 1989 until early 1992, and Phase II from mid-1992 until program phase-out in September 2000.

2.1. Phase I (1967-1988)

USAID assistance for family planning in Brazil began in the late 1960s with support via International Planned Parenthood Federation (IPPF) for the newly created NGO, BEMFAM, which became a formal IPPF affiliate in 1967. During the late 1960s and early 1970s, the program expanded to support other Brazilian NGOs that provided family planning services, trained providers, and carried out basic demographic and operational research. USAID was the pioneer and the major donor supporting family planning for decades. The United Nations Population Fund (UNFPA) and the Ford Foundation were the only other consistent sources of funding during this period. This strategy of supporting Brazilian NGOs continued until the late 1980s when, within the context of Brazil's shift back to democratic rule, a transition was initiated towards a broader strategic focus that would redirect USAID support more toward Brazil's public sector and the commercial private sector.

The USAID/Brazil family planning strategy was generally consistent with a broader USAID/Brazil assistance strategy that concentrated on building strong Brazilian institutions ("centers of excellence").[6] However, because the GOB had made no formal policy and program commitment to family planning, family planning assistance was always funded through USAID global or regional programs, rather than through the government-to-government programs that the other sector programs used until bilateral assistance was phased-out in the early 1970s.[7] The recipients of USAID family planning assistance were NGOs and some universities working in this sector, rather than government or government-supported institutions.[8]

USAID/Brazil formally closed its doors in 1975 as Brazil's per capita income made it difficult to justify continuing U.S. foreign assistance. However, the centrally funded family planning program continued in Brazil, managed by a Development Attaché in the U.S. Embassy. USAID/Brazil re-opened its office in 1985 as Brazil's economy deteriorated, and in order to provide support for Brazilian institutions working on several key "global problem areas" such as

[6] The "Centers of Excellence" strategy was required of donors by the Government's strong Ministry of Planning office that approved all donor grant assistance. In many sectors, the results of this USAID assistance to priority Brazilian institutions were extremely successful (establishment of the Agricultural Research program, establishing a network of agriculture universities on the U.S. land grant model at Vicosa, Univ. of Ceará and Piricicaba, establishment of Brazil's Seed Multiplication program, the Brazilian Institute for Municipal Development -IBAM, the Brazilian National Academy of Science -CNPq, and many others).

[7] The huge USAID bilateral assistance program of over $100 million/year in direct loan/grant and PL-480 food aid was phased-out in 1974 after almost eight years of "miracle economic growth" in Brazil. USAID felt that its limited resources should be transferred to more needy countries.

[8] The 1982 constitution recognized a citizen's right to control his/her reproductive health, but the major government program to implement a maternal health program, PAISM, was stalled throughout the 1980s due, primarily, to Catholic Church opposition.

HIV/AIDS, global warming/climate change, and family planning. Due to U.S. Congressional restrictions, none of the post-1985 USAID assistance could be provided directly to the federal government; aid had to be channeled through NGOs, the private sector, and individual states.[9]

During Phase I, the various USAID family planning strategies consistently had four foci within overall objectives that were usually stated in language similar to the 1985 strategy: "to enhance the freedom of individuals … to choose voluntarily the number and spacing of their children" and "to encourage population growth consistent with the growth of economic resources and productivity."[10]

The first focus area encouraged a more positive official Brazilian Government policy towards family planning - primarily through RAPID[11]-type presentations that graphically demonstrated the social and economic consequences of rapid demographic growth. The policy component also supported the Brazilian Association of Family Planning Organizations (ABEPF), formed in 1981 by prominent Brazilian family planning leaders, and representing over 200 autonomous Brazilian organizations that offered family planning services. ABEPF served as an advocacy organization for family planning and also provided training and materials to its members. [12]

Second, during Phase I, USAID supported basic demographic research, as well as operational research on new contraceptive methods and their use.[13] The program promoted training for carrying out surveys and use of the resulting data for research on fertility determinants. It also funded operational research on ways to improve service delivery.

Third, about 40 percent of USAID resources supported service delivery systems. USAID supplied contraceptives, training, and financial support primarily to BEMFAM and Centro de Pesquisas de Assistencia a Mulher e a Criança (CPAIMC)[14] and ABEPF that used some of this support for their clinics but passed most of the support on to many of the 200 Brazilian entities that belonged to ABEPF. BEMFAM also supplied methods and training to the hundreds of municipalities and states with which they had *convenios* or contracts. The family planning methods supplied were those available at the particular time. Until the early 1980s, these were oral contraceptives, condoms, and equipment for "high risk" surgical contraception. IUDs also were provided but fell out of favor in Brazil (and elsewhere) after the Dalkon Shield controversy in the United States in the mid-1970s. USAID also supported male involvement in family

[9] Indirect aid had to be channeled through NGOs, the private sector, and individual states because of Brazil's non-signature of the Nuclear Non-Proliferation Treaty. In addition, Brazil payments on U.S. Government loans was in arrears.

[10] Taken from a 1983-88 USAID population strategy document, but likely to be very similar to earlier strategy documents.

[11] Resources for the Awareness of Population Impacts on Development (RAPID).

[12] This listing of activities is illustrative and does not attempt to include all USAID-funded activities throughout this 20-year period.

[13] Through cooperative agreements with the Population Council, Family Health International (FHI), and others.

[14] CPAIMC, established in 1975, ran 44 clinics and operated a hospital in the Rio de Janeiro metropolitan area. It also trained hundreds of Brazilian doctors, nurses and nurse auxiliaries in its training programs on surgical contraception procedures for high-risk women and on provision of services to post-partum women. CPAIMC also conducted operational research and carried out urban maternal/child health programs. It received UNFPA assistance as well as USAID support.

planning, primarily through support for Promoção da Paternidade Responsavel (PROPATER)[15], a pioneering São Paulo institution that specialized in vasectomy.[16] The USAID program also worked to reduce Brazil's legal obstacles and tariff barriers to the importation of medical equipment, foam, jellies, and oral contraceptives, as well as quality IUDs and condoms not manufactured in Brazil.

Training and the development of educational materials for providers and clients made up the fourth major component of USAID Phase I assistance. Thousands of young physicians, nurses and nurse auxiliaries became exposed to family planning through short-term training programs in Brazil and outside of Brazil.[17] Through these courses they acquired the technical knowledge, favorable attitudes, and practical skills that enabled them to initiate and carry on family planning service provision through the NGO sector programs.[18]

Modestly successful attempts were made to introduce family planning (and later reproductive health) into the curricula of Brazil's medical schools.[19] The latest technical information was provided to Brazilians through programs that translated key technical documents and monthly journals into Portuguese. Finally, educational materials for clients on all available contraceptive methods were developed and distributed to NGO service sites and to municipalities with BEMFAM contracts.

2.2. Transition Period (1989-1992)

Twenty years of military rule in Brazil ended in 1984. As a democratic government took hold, USAID began to consider several new ways to provide family planning assistance to government entities in Brazil. With the new Brazilian constitution of 1988, and the initiation of SUS, responsibilities for the finance and provision of social services were gradually being decentralized from the federal government to the Brazilian states and municipalities, government units where USAID assistance was not prohibited. In addition, USAID/Washington policies encouraged new attempts to work with the private sector to achieve program objectives, especially in relatively developed countries such as Brazil. Another key factor was the 1986 Demographic Health Survey (DHS) that, for the first time, provided national data on reproductive health status. The DHS clearly showed major differences in demographic indicators between Brazil's poorer Northeast region and the more developed areas of Brazil. It was clear

[15] In the 1980s, USAID supported a successful initiative to promote the uptake of vasectomy in the state of São Paulo. PROPATER used a number of innovative communication strategies to reach out to men in labor unions and other groups and to promote the idea of male responsibility for fertility regulation. The approach brought a substantial response. With the decision to focus USAID support on the Northeast, support for PROPATER was not continued after 1992.

[16] Much of the service delivery support to Brazilian institutions was provided via USAID CAs such as Family Planning International Assistance (FPIA), Pathfinder Fund, and the Association for Voluntary and Safe Contraception (AVSC).

[17] Development Associates, JHPIEGO, AVSC, Pathfinder and others provided training in Brazil. USAID worldwide training funds were used to provide scholarships and short-term training grants for courses in the United States.

[18] MSH final report, p. 1.

[19] JHPIEGO and Pathfinder took the lead in these efforts. At a national Pathfinder-supported conference in the mid-1980s, fifteen medical school deans indicated that they had introduced or planned to introduce family planning into their curricula.

that USAID's focus would need to shift to the Northeast where fertility rates were higher and contraceptive prevalence lagged considerably behind country-wide indices.

USAID encouraged NGOs such as CPAIMC, ABEPF, PROPATER and others to develop "sustainability plans" as it began to phase out assistance. Most of these organizations did not survive the transition, at least in the same form. The sustainability efforts did not succeed and no other donor was available to replace USAID assistance. A contributing factor also was the aging of the cohort of initial leaders in Brazil's family planning movement. BEMFAM did not need to develop a sustainability plan at this time since much of its work was concentrated in the Northeast and USAID assistance was likely to continue.

2.3. Phase II (1992-2000)

A new strategy for USAID family planning assistance to Brazil, designed in July 1992, noted that the high overall contraceptive prevalence data in Brazil (66 percent in 1986) masked disturbing realities. Almost 80 percent of contraceptive users relied on only two methods, female sterilization and oral contraceptives. In the Northeast, which lagged behind the rest of the country, the use of oral contraceptives was declining, and there was a growing reliance on female sterilization (and, although not measured in the DHS, abortion).[20] Therefore, the new (and final) USAID strategy would focus on improving the quality of family planning programs to poorly served populations in the Northeast. Quality would be improved by expanding the choice of methods broadly available to women, improving counseling, and making better information available to clients for contraceptive choice and proper method use.

The new strategy's second objective was "to promote the sustainability of family planning in appropriate delivery systems".[21] This strategy would focus much less on NGOs and would work directly with state health systems in two large Northeastern states, Bahia and Ceará, where needs were obvious and there was a clear desire to improve existing state health services. The program also, for the first time, placed a high priority on "accessing the resources and network of the private commercial sector and its capacity for service delivery, commodity production, and distribution."[22] The strategy hypothesized that if large-scale health maintenance organizations (HMOs), third-party insurance, and group medicine plans included family planning in their basic health plans, the broader method mix would be available for the first time to the rapidly growing portion of the Brazilian population using these private sector plans.

Program sustainability was a major focus, especially since the strategy clearly stated that USAID assistance for family planning would gradually phase out over the eight-year period and would terminate at the end of the strategy period, the year 2000. Thus, the new state-supported programs in Bahia and Ceará would need to be self-supporting or receive other donor funds[23] by

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[20] "Strategy for USAID Assistance to Family Planning to Brazil, 1992-2000", July 1992

[21] Ibid p. 15.

[22] Ibid.

[23] One element of the strategy was to significantly widen the number of donor organizations and foundations providing support for reproductive health/family planning in Brazil. Bilateral donors, such as JICA, UN agencies, and the multilateral lending agencies (World Bank, Inter-American Development Bank) were possible new sources of funding.

2000, and BEMFAM also would need to be financially self-sufficient. A major concern was whether family planning contraceptives, provided in large quantities by USAID for decades, would continue to be available to users at reasonable prices.[24]

The new strategy recognized that family planning services needed to be provided within the context of Brazilian service delivery systems that focused broadly on reproductive health, women's health, and family health. Efforts were made to work more closely with the influential Brazilian women's movement in order to encourage stronger and better-financed government health programs and to promote appropriate health policies. USAID participated actively in the in-country preparatory meetings leading up to the ICPD meeting, and financed the participation of some key women's organizations at that meeting. The Cairo philosophy focusing on women's reproductive health as a human right was adopted by the USAID Mission and by USAID-funded CAs working in Brazil, and has been fully incorporated into the Quality Improvement Project (PROQUALI) initiative that began in 1996.

During the early 1990s, USAID/Brazil also initiated a new program strategy for its pioneering work in HIV/AIDS in Brazil[25] and designed a major new program, At-Risk Youth Project (POMMAR), to address the problems of "at-risk youth" in the Northeast. Efforts were made to ensure integration of these programs with the new family planning strategy as much as possible.

2.3.1. Mid-term Strategy Evaluation

In 1995, a mid-term strategy evaluation concluded that the decision to focus assistance "on a few issues (quality of services, sustainability, private/public roles), a few activities to address those issues (training, IEC, commodities, investment in for-profit activities, and research/evaluation), and in two states of Brazil's poorer Northeastern region was a sound one."[26] Given the short phase-out period remaining, its major recommendations included a new "management" component in the two state program, and to avoid any new private sector ventures (after the failure of UNIMED, a Brazilian HMO's pilot activity).[27]

The achievements (and failures) of the Phase II strategy (1992-2000) are discussed in detail in the following chapter.

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[24] Purchased by governments at the municipality, state or federal levels for government health facilities, purchased and provided by BEMFAM through convenios, or provided by other donors.

[25] This work had begun in the late 1980s through USAID initial efforts worldwide to address the new disease: AIDS Technical Assistance Project (AIDSTECH) and the USAID AIDS Communication Program (AIDSCOM). Until the World Bank provided a loan to the Brazilian government in 1994, USAID was the only major donor supporting HIV/AIDS prevention efforts in Brazil.

[26] "Mid-Term Evaluation - Strategy for USAID Assistance in Family Planning to Brazil". 1995. p. 8.

[27] This pilot project was to establish an outreach clinic for lower income beneficiaries, and include family planning benefits in its package.

3.0. PHASE II: PROGRAM ACHIEVEMENTS

3.1. National and Regional Level

3.1.1. The Changing Policy Environment

The overall policy environment for FP/RH in Brazil is much more open and supportive today than it was when USAID's phase-out strategy was decided. At that time, the program was still dealing with the legacy of more than two decades of antagonism and opposition to organizations supported by the program. This antagonism was based on a number of factors including concerns inside and outside the Brazilian public sector about foreign interference in an arena in which Brazilian national interests were closely guarded; and opposition by the Brazilian women's health movement to what they perceived as population control rationale for USAID's early support of family planning in Brazil.

While some resistance persisted, the overall climate became much more amenable during the 1990s. The new vision of population and reproductive health that emerged from what is known as the Cairo process (including the lead-up to the meeting, as well as the meeting itself in which Brazilians played a pivotal role), contributed significantly to the changed environment. Brazilian women's health advocates were major players in the Cairo process and helped forge the client-focused reproductive health approach to family planning and other family health issues that were agreed upon in the ICPD program of action. There is now clear government support for FP/RH, and the recent move by the maternal health group to the policy secretariat places it more in the MOH mainstream. This is important because that group will design and manage the expanded FHP that is being proposed for a World Bank loan.

The Cairo process was embraced by BEMFAM and other agencies supported by USAID's family planning (now FP/RH) program. The Cairo vision provided a roadmap for those agencies to reorient their approach in directions that invited former detractors to recognize their positive contributions to reproductive health and rights in Brazil. USAID played a significant supportive role by facilitating the participation of both USAID-supported Brazilian family planning NGOs and Brazilian women's health advocacy groups in the Cairo process, by urging its CAs to adapt to the changes brought by Cairo, and by encouraging dialogue among the protagonists.

USAID and its CAs wisely maintained low profiles in the policy arena in the years after Cairo. National groups such as the National Commission for Population and Development, the National Women's Reproductive Health and Rights Network, and Centro Feminista de Estudos e Assessoria (CFEMEA) took the lead in the development of national policy on population, FP/RH and rights, including legislative action to establish regulations for surgical sterilization and other aspects of fertility regulation. They continue to play an active advocacy role in the legislative and regulatory arenas, in mobilizing public support for reproductive health and rights, and in heading off potentially damaging initiatives by forces opposed to family planning and reproductive health and rights.

Key Benchmarks in Reproductive Health and Family Planning in Brazil

- 1965 – Brazil's IPPF affiliate, BEMFAM, is founded
- 1974 – At the Bucharest population conference, Brazil's military government supports access to family planning but rejects population control
- 1984 – Re-establishment of civilian government with major involvement of women's groups; integrated women's health program (PAISM) established
- 1986 – Brazil's first DHS survey
- 1988 – New constitution guarantees free health care and the right to family planning for all Brazilians; Unified Health System (SUS) launched
- 1989-93 – Economic and fiscal crisis undermines implementation of SUS and PAISM
- 1992 – Brazilian women's groups mobilize against population control and for women's reproductive health and rights during global environment conference in Rio
- 1994 – New government introduces REAL plan to stabilize economy; launch of Family Health Program for primary care; Brazil plays major role in new approach to population during Cairo population conference
- 1997 – Family planning law approved after seven years of debate; sterilization is made legal and regulations established
- 2000 – End of USAID Phase II program

USAID CAs played critical supportive roles for these efforts by providing technical guidance, and by helping to overcome such regulatory obstacles as tariff barriers and cumbersome testing procedures for condoms. The CAs assisted in the introduction of contraceptive methods in order to broaden the range of contraceptive choices for Brazilian couples, including the development of norms, and providing technical input, training, and operational research on new and existing methods. USAID also worked to expand donor support for reproductive health in Brazil.

The programmatic and epidemiological environment did not remain static over the 1990s. The decade witnessed important changes in the health sector brought about by the implementation of several reform initiatives, including a major move toward decentralized financing and the management of health services – all against the backdrop of tumultuous macroeconomic and fiscal upheavals. There also was growing recognition of and programmatic responses to Brazil's HIV/AIDS epidemic, adolescent reproductive health challenges (including earlier sexual debut, unwanted pregnancies, exposure to sexually-transmitted diseases (STDs), and sexually-related violence), and a growing inequity in access to basic health services.

The municipalization of health services posed additional policy challenges because of the large number and high turnover of officials responsible for spending decisions and priority-setting in health services, which required that interventions include not only technical support and oversight, but also on-going efforts to build and maintain political support at all levels.

3.1.2. Support for Research and Data Development

USAID's support for research and data development played a highly significant role in building up the evidence base for population and reproductive health policy and program development in Brazil both before and during the phase-out period. The partnership between BEMFAM and

USAID CAs supported two national-level DHS surveys (1986 and 1996), as well as a Northeast Regional Survey in 1991. BEMFAM is currently initiating another national survey with MOH financing using World Bank and Inter-American Development Bank (IDB) supported Reforço do Sistema Unico de Saude (REFORSUS -- Reform of the GOB Unified Health System) program funds. These surveys have contributed enormously to the awareness of population and reproductive health issues at all levels, in addition to being the basis for program design and evaluation by the MOH, state Health Secretariats, and various donors.

The Population Council's operational research program also has contributed through the implementation of baseline and follow-up situational analysis on service delivery issues in the two states selected for USAID program support during the phase-out, as well as research to support the introduction of contraceptive methods, improved service delivery quality, and community participation in program management. These initiatives were implemented in a manner that also contributed to the development of a national capacity to continue working with this methodology.

The fact that this survey work is continuing after the phase-out with the 2001 DHS conducted by BEMFAM with MOH support is a clear indication that sustainable capacity was developed.

3.1.3. Increased Choice of Contraceptive Methods

One of the major programmatic concerns at the time the Phase II strategy was designed was the narrow range of fertility regulation options available to Brazilian women. There was heavy reliance on surgical sterilization, along with substantial but declining pill use; limited but growing condom use; and probably high, but difficult to document, reliance on abortion because of contraceptive failure, or lack of access to appropriate methods. Efforts to broaden contraceptive choice were undertaken at the national level as well as in the states of Bahia and Ceará.

At the national level, USAID CAs supported research, training, and regulatory work on the introduction of new methods, and the reintroduction of the IUD which was underutilized. Working in partnership with the MOH and the Brazilian Federation of Societies of Obstetrics and Gynecology (FEBRASGO), the Population Council's Brazil office convened a series of workshops on contraceptive technology that led to MOH incorporation of emergency contraception (EC) in the public sector program. The Council also worked with a Brazilian pharmaceutical company to arrange an agreement for registration and commercialization of a dedicated EC product, and maintains an internet site to enable providers to seek information on method safety and efficacy issues.

The Population Council conducted research on the acceptability and clinical performance of the female condom being promoted for women at risk of being infected by HIV/AIDS, on the levonorgestrel-releasing intrauterine device, and on diaphragms used continuously without spermicide or before intercourse with spermicide. The Council worked closely with the World Health Organization's (WHO) special program on human reproduction in designing a contraceptive introduction strategy for Brazil. This strategy put special emphasis on community participation and oversight, and on the quality of service delivery, both of which were very

important given the strongly adverse reaction to an earlier, but poorly implemented effort to introduce contraceptive implants in Brazil.

USAID-supported private sector and contraceptive social marketing initiatives (Social Marketing for Change (SOMARC), Promoting Financial Investments and Transfers (PROFIT) and later Commercial Marketing Strategies (CMS)) also contributed to an expanded range of method choice, through partnerships with Pharmacia-Upjohn and Organon, by introducing and marketing their three-month injectables (Depo-Provera and Triciclon). The PROFIT project collaborated with SOMARC and Pathfinder International in setting-up a contraceptive supply company, Importãçao e Comércio de Insumos Farmaceuticos Ltda. (CEPEO), which brought reasonably-priced IUDs back onto the Brazilian market, along with supplying a range of other products including spermacides and diaphragms. CEPEO is a major national distributor of diaphragms and the female condom, and within the first year of sales in 1995 became a leader in the Brazilian IUD market.

Although a broader choice of methods was becoming available, the 1996 DHS showed little change in the use of methods, as there was a continuing heavy dependence on surgical sterilization. In fact, if the number of women who had been sterilized in prior years is taken into account, it is likely that the proportion of new contraceptive users opting for sterilization actually rose during the early 1990s. Population-based samples, such as the DHS, reveal a contraceptive pattern that changes slowly and gradually. Even with a broader contraceptive choice available for non-sterilized women, any increase in the use of modern contraceptive methods will only gradually reduce the statistical weight of the large number of women already sterilized.

Available program data suggest that pill use stayed level or declined slightly. While there was some uptake in IUDs and injectables, their market share was still limited due in part to physician reluctance to recommend new methods. Condom use rose in response to increased awareness of the risks of STDs and HIV/AIDS, but also was limited. Definitive conclusions about changes in Brazil's contraceptive method mix will have to wait for the results from the 2001 DHS-type survey to be conducted by BEMFAM.

Substantial barriers to expanded use of new methods remain on both the provider and user sides. The incentive system for providers is still biased against methods that require counseling and follow-up which, in the case of the IUD, exacerbates a pre-existing resistance to the method. Consumers lack information on the risks and benefits of alternative methods, and provider training on counseling and the client-provider communication process has been limited.

Pharmacies remain the main source of supply for pill users (about 90 percent, according to DHS data). There has been improvement in procurement of methods for distribution through the public sector; a number of states (including Bahia) and some large urban municipalities now purchase contraceptives. For the first time, the MOH is launching a major national procurement initiative for pills, injectables, IUDs, and diaphragms. BEMFAM continues to supply methods through its contracts with about 1,000 municipalities, and is now purchasing methods on the open market rather than depending on donated supplies, as was the case five years ago. BEMFAM also has had considerable success with its PROSEX condom program, expanding its sales points to include newsstands and convenience stores. In addition, there has been a major

expansion in the social marketing of lower-priced condoms by Digitagle Kommunications Technik (DKT) under the USAID-supported HIV/AIDS program. These two socially-marketed condoms now make up 16.9 percent of the Brazilian condom market.[28]

Despite improvements, longer-term prospects for method availability remain somewhat problematic. With decentralization, municipalities eventually will be responsible for procurement. Family planning is included in the basic service package that municipalities share in financing under SUS, but not all municipalities actually spend this money on family planning.[29] Methods are not yet included in the basic medicines package available to municipalities, though states may modify the content at the state level. Ceará decided in April 2000 to include low-dose pills in the state package. The MOH procurement is reported to be a three-year "transitional" measure in response to the urging of women's health advocates that the MOH ensure a supply of methods while the states and municipalities develop their capacity to manage such procurements on a sustained basis.[30] It is not at all clear that smaller municipalities will be able to procure methods at reasonable prices other than through BEMFAM contracts or through a form of "buyers club" arrangement; indeed, many municipalities are buying other medicines at retail, rather than wholesale prices. The MOH and others also informed the Mission that existing information systems were inadequate for assessing requirements at various levels, and that they were planning to remedy this by adopting the SISMAC management information system being developed in Bahia by Pathfinder International.

3.1.4. Private Sector Initiatives

The decision to focus program investments in two Northeastern states during the phase-out necessarily involved trade-offs among national-level areas of program focus. This resulted in somewhat less focus on private commercial involvement in family planning than might have been the case had the phase-out strategy been national in scope or focused on states (São Paulo, for example) where there was a greater concentration of private-sector involvement in health. Nonetheless, there were some notable achievements that flowed from earlier private-sector initiatives.

One notable achievement is the contraceptive supply company, CEPEO, which was launched by the PROFIT project as a mechanism for importation of IUDs. PROFIT sold the company to its managers when the project closed. CEPEO, still based in Salvador, Bahia, is a profitable company. It has expanded its product line and now sells to a substantial number of physicians across Brazil in addition to being a vendor to the federal, state, and municipal governments, most notably in Bahia. After winning an international bid to supply IUDs to the MOH, CEPEO is

[28] "Report on CMS and Other USAID Centrally-Funded Reproductive Health Projects in Brazil". CMS, March 10, 2000, p. 6.

[29] Nor do some municipalities spend the funds for health more generally. There are reportedly no sanctions if a mayor decides to use his "health" funds received from the federal government for other activities.

[30] The "transition" will be difficult since the federal government share of method provision is scheduled to increase from 30% to 60% to 100% of SUS requirements over the three-year period (2000-2002) rather than decrease, gradually reducing the incentives for municipalities and states to purchase their own contraceptives and making them more dependent on federally-provided contraceptives.

under contract to provide 158,000 units by August 2000. By June 2000, 78,000 had been supplied.

PROFIT was less successful in its efforts to engage UNIMED in establishing family planning as part of its benefits package, and in providing lower income beneficiaries with access to these services through an outreach clinic. Local management did not deliver on commitments, and eventually agreed to buy out the 49 percent share of the hospital in which PROFIT had invested. The funds were given to Pathfinder International's office in Salvador to support other USAID-funded family planning activities in the Northeast.

As noted earlier, the contraceptive social marketing program that was started under SOMARC and continued under CMS contributed substantially to the effort to broaden the number of methods available to Brazilian consumers. SOMARC provided technical support to BEMFAM's contraceptive distribution program and brokered the partnership with Pharmacia and Upjohn to introduce Depo Provera in Brazil. CMS continued the technical support to BEMFAM and the partnerships with pharmaceutical companies, including work with Organon on their three-month injectable, and with ACHE Laboratórios Farmaceuticos (ACHE) on emergency contraception. This work included an effort to ensure that these products were available at prices low/middle-income consumers could afford, in exchange for which SOMARC, and later CMS, assisted in the introduction effort. CMS also worked with the business community on a social responsibility project that focused on reproductive health and rights issues.

While the phase-out strategy achieved less in the private sector arena than might have been possible with a different investment strategy (for example, had there been more work with private insurance companies), the contributions are, nonetheless, significant. The technical support to BEMFAM's condom initiative was a critical element in the turnaround of BEMFAM's sustainability prospects, which were judged to be perilous at the time of the 1995 review of the strategy. The social marketing initiative for family planning complemented efforts in the HIV/AIDS arena, so that socially marketed condoms, in 2000, account for 16 percent of a rapidly growing market. The partnerships with major pharmaceutical companies demonstrated that it is possible to attract the industry's interest to socially important initiatives such as the introduction of emergency contraception. The one disappointing area is the continued lack of inclusion of family planning in benefits packages offered by insurance companies and HMOs (except for the initiative by Promedica in the Northeast, which benefited from USAID support in the 1980s). These companies serve an estimated 45 million of Brazil's 160 million people. Experience elsewhere has shown that when consumers advocate for changes in the content of benefits packages, it is possible to change company policies.

3.1.5. BEMFAM

BEMFAM, a Brazilian NGO that is an affiliate of IPPF, received continuous financial, technical, and commodity support from USAID since its founding in 1965. During Phase II of the USAID program, primary emphasis was placed on ensuring the eventual financial sustainability of BEMFAM after USAID's departure. This effort has been largely successful, after a slow start. BEMFAM reported in 2000 that it was 91 percent self-sufficient. Its increased sustainability was achieved through the:

- introduction and sale of the PROSEX condom marketed via a new Social Marketing Department;
- improved profitability and promotion of BEMFAM's clinics and clinic laboratories in Fortaleza, Recife, and Rio de Janeiro;
- improved internal cost controls and re-engineering within BEMFAM to establish a new environment that combines social service and financial sustainability objectives;
- greater variety of services offered via *convenios* with Brazilian municipalities (864), states (Rio Grande do Norte, Paraiba, Alagoas) and the private sector to include STD/AIDS prevention, health and sexual education, youth education, municipal health management, information and logistics systems, and situational analysis;
- diversification of product lines available for donor funding, that include AIDS prevention (Projecto Mulher, sex education and STD/AIDS prevention in schools), adolescents (project PROJOVEN), involvement of men in reproductive health (Projeto Homen), cervical cancer screening, provision of technical assistance to Lusophone African countries, demographic data collection/dissemination; and
- diversification of funding sources: United Nations Childrens Fund (UNICEF), United Nations Population Fund (UNFPA), British Department for International Development (DFID), Canadian International Development Agency (CIDA), MacArthur, other foundations, the MOH, and others.

3.1.5.1. BEMFAM Support to the Northeast Region:

Although BEMFAM has gradually diversified, its best-known and most significant program continues to be the support of reproductive health services to municipalities through *convenios.* A typical, traditional *convenio* provides a municipality with a) training twice each year for the municipal health team as well as some on-the-job training; b) monthly supervisory visits to each participating health post; c) a steady, monthly supply of reversible contraceptive methods (pills, condom, diaphram, IUD, injectables and jellies); d) training on BEMFAM's system of stock management and record keeping for clients and methods; and, e) supplies of IEC materials on sexual/reproductive health and STD prevention for clients.

"*BEMFAM is the salvation of most small municipalities*" - senior Ceará health professional.

In recent years, BEMFAM has broadened and diversified the menu of services that it offers through *convenios*. This reflects an effort to respond to the broader reproductive health guidelines of Cairo (and to be "not just a family planning program"), to fit with the reproductive health programs of Brazilian states and client demands, and to make a move towards financial sustainability.

Through these *convenios*, BEMFAM presently serves two million clients through health posts in approximately 1,000 municipalities, mostly in the Northeast. Since municipalities must pay for BEMFAM services (negotiated supposedly to cover BEMFAM's costs), there is strong evidence that BEMFAM's services continue to be valued, especially at the local service delivery level. BEMFAM provides services to 60-90 percent of all municipalities in these poorer states. The

total number of contracts has recovered to over 1,100 (the same level as in 1994, prior to the initiation of BEMFAM consolidation and its cost-recovery efforts). Total service levels have grown to 2.37 million clients, a 22 percent increase from a 1997 low, but still below early 1990s levels due partly to the consolidation of services covered under the contacts. Even in Bahia, which has experienced a rapid increase of state-supported family planning services in the past decade, BEMFAM reports that 85 percent of all municipalities (a growing number) now have *convenios* with BEMFAM. [31] However, some municipalities that now receive contraceptives from the Bahia state government have not renewed their BEMFAM convenios.[32]

In sum, BEMFAM is well on its way to financial sustainability, is providing valuable and increasingly diversified services, and has an essential advocacy role to play nationally on reproductive health issues. However, the medium-term future of its largest program (the *convenios*) is uncertain. If the federal and state governments begin to fulfill their legal responsibilities in reproductive health through Family Health and/or PROQUALI-type programs, then BEMFAM *convenios* may become less needed by municipalities. This team's assessment, however, is that BEMFAM contracts that provide "good value for money" are likely to continue to be in strong demand, especially in the poorer and more rural municipalities of the Northeast. These proven cost-effective services also would be valuable in the underserved North region, but as a newly self-sufficient organization, BEMFAM would clearly need an outside infusion of funds to expand its services to states in that region or elsewhere.[33]

3.2. Qualitative Initiatives

3.2.1. PROQUALI

During 1995-97, USAID urged family planning health staff, the state Health Secretariats, and three of the CAs (JHPIEGO, JHU/PCS, MSH) to work together on family planning in Bahia and Ceará states, and to develop a strategic approach and tool kit for continuous quality improvement in FP/RH. The process, which led to an innovative and very useful and effective product, was motivated by a strong common sense of the need to address quality of care in a coherent, systematic, and locally applicable way.

PROQUALI is a client-focused model aimed at a sustainable system for quality reproductive health services at the clinic level. It constitutes a further development of the Quality Assessment Program (Client-Oriented, Provider-Efficient Services (COPE)) model developed by AVSC and the Gold Star program in Egypt, adding components in management training and accreditation.

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[31] "BEMFAM Final Report: BEMFAM/USAID Partnership, 1992-2000". March 2000.

[32] Although SESAB officials believe that this has occurred, BEMFAM reports that the total number of agreements in Bahia rose from 132 in 1996 to 162 in May, 2000.

[33] In response to this report, BEMFAM notes that they provide a large variety of "convenios" with a clear focus on sustainable initiatives for quality improvements and that they have agreements in the South and Southeast regions that continue to be in strong demand.

In brief, the staff team of a health facility that has decided to improve the quality of care with the model agrees to:

a) perform a self-assessment of the quality of reproductive health care provided, using defined quality criteria;
b) perform a set of client-exit interviews regarding quality of care provided, with complaints and suggestions, using defined question and answer models;
c) develop and implement an action plan based on the above;
d) accept onsite technical assistance and skills building to reduce gaps identified in the asssessment;
e) repeat the assessment after agreed improvements have taken place;
f) apply for accreditation as a PROQUALI unit, when internally satisfied with improvements; and
g) receive accreditation (with plaque, ceremony, etc.) once an independent outside team finds that the health facility has fulfilled the defined quality criteria.

The systematic approach to self-evaluation and client interviews has created a strong sense of ownership and self-determination among service provider staff at the health posts to meet the criteria for program accreditation. This has proven very effective in mobilizing local commitment and resources. Systematic listening to clients on the one hand – a novelty – together with help in improvements has made a tremendous difference. Interventions have included managerial training, team-building exercises, and in-service training of staff in essential reproductive health care. During the development work, generic standards for reproductive health care have been developed, and quality criteria also have included areas such as waiting time, hygiene, and clients' access to informational material.

As noted above, increasing access to a broader range of contraceptive methods was an important part of the effort to provide Brazilian women with greater choice in fertility regulation. Another dimension was improvement in the quality of service delivery for those methods. Both the content and the implementation approach of the PROQUALI program contributed to improved method choice. PROQUALI addresses the technical quality of service delivery. For example, PROQUALI stresses avoiding infection when providing IUDs – recognizing that infection has been a key problem with IUDs in the past – along with better counseling on the risks and benefits of alternative methods. Preliminary evidence from PROQUALI clinics suggests that the use of alternative methods has improved and is growing faster than in other clinics.

A systematic delegation of responsibilities to non-physicians also has taken place. Selected nursing auxiliaries now give group education on FP/RH, before individual counseling is handled by the nurse. The specially trained auxiliaries also handle regular return visits for family planning provision, and nurses are needed only when difficult questions arise. In standard family planning provision, this means that doctors are needed only for complicated cases and for IUD insertion. Many doctors work limited hours in each clinic, and often live elsewhere, while paramedical staff work full-time in the same clinic and often reside in the neighborhood in which they serve. This model has greatly increased ownership and self-esteem and the will to improve even further.

"*This is the first intervention in 25 years of public health service that hasn't disappointed me*" - a statement about PROQUALI by a health specialist in interior Ceará.

The in-service training provided has been linked in time to the improvement of the local unit, and in content to the standards of essential reproductive health care developed -- from hygiene to communication skills. The administrative staff has received support for improving contraceptive commodity logistics and client records.

The systematic use of IEC materials played a central role in PROQUALI, both for use in group education on family planning, prenatal care, etc., and for regular distribution to all clients. The IEC materials are part of a larger communication strategy, summarized below.

Management training of facility leaders has involved leadership, commodities and logistics, reporting and information procedures/systems (see summary of SISMAC software), and the handling of the PROQUALI process.

External inputs for introduction and implementation of PROQUALI (once local criteria and guidelines have been developed, and experience gained locally) can be summarized as follows:

Installation:

- a Quality Improvement Team to introduce and lead the process for in-service training;
- physical improvements financed by the municipality;
- reliable provision of commodities; and
- an independent assessment team for accreditation.

Maintenance:

- the Quality Improvement Team support;
- client/community participation in advocating for continued quality services;
- regular re-accreditation;
- in-service training when need arises (additional areas); and
- training of personnel transferred into PROQUALI facilities.

It is well-known that quality improvement of health care – a challenge everywhere – is a continuous or cyclical process, never finished, and that it must be based on local criteria/standards and regular assessment of the fulfillment of those standards. PROQUALI has provided the tools and implementation strategy for such continuous quality improvement of reproductive health care in Brazil.

"*The change in behavior and services at the health post is almost a miracle*." Comment by a senior SESA/Ceará official, March 2000.

In the initial pilot phase, it quickly became clear that it would not be possible to limit the quality improvements in a health facility uniquely to the family planning services and, thus, the scope of PROQUALI embraces the full range of basic reproductive health services. As a consequence of the promising results from the pilot study, criteria have now been developed, or are under

development in other areas of primary health care (PHC) in the same facilities. The State Health Secretariats consider the PROQUALI model a very promising approach for improvements of primary health care at large, and do not regard it as exclusively a reproductive health model. Potentially, it fits well with both municipalization and decentralization, as well as the Government's Family Health Care program.

"*In many locations, PROQUALI didn't improve services, it got them started*." CA professional referring to both rural and urban health centers in Bahia and Ceará.

In summary, PROQUALI is an attractive model for improving primary health care services through a client-centered approach, involving all staff in an effective and participatory way. It has created much interest outside the FP/RH field, both in Bahia and Ceará states, and elsewhere in Brazil. The state of Sergipe has requested and received Secretaria da Saude/Bahia (SESAB) support in management training for state health personnel and the state of Rio Grande do Norte is the site for a UNFPA-funded pilot PROQUALI program. Despite its promise, implementation of PROQUALI is still in its initial stages, and it will need wider implementation to find its final shape.

3.2.2. Pre-service Training

An innovative Pathfinder program led to the inclusion of FP/RH curricula in 15 medical faculties during the 1980s, and activities in this field have continued over the years, increasingly with FEBRASGO as a partner. Initial work, to a large extent, focused on improved delivery of a few, selected family planning methods; work during the 1990s emphasized a broader contraceptive choice based on clients' views regarding counseling.

During Phase II of the USAID program, systematic efforts were made to further develop pre-service training in reproductive health in two universities in Bahia and Ceará. Most resources were spent on medical curricula at the university level, with fewer resources devoted to attempting to support curriculum development for nurses. The technical assistance and financial resources invested in developing medical students' curricula and training was greatly appreciated at the university level. The fact that the support, in principle, was dedicated to family planning and not reproductive health in general created some challenges, as many academic staff felt the need for support for reproductive health pre-service training at large.

Medical curricula everywhere tend to reflect the national academic tradition regarding: the scope of a subject; distribution of time; curative vs. preventive; hospital-based or community- oriented; basic public health approach or high-tech; evidence-based or based on "traditional practice"; using standard guidelines or individualistic approach; hands-on or theoretical; and oriented towards specialist or generalist care, etc. Such traditions take considerable time to change. The challenges experienced by the CA (JHPIEGO) working in this area indicate that five years of collaboration is a minimum to achieve any significant impact. A reflection of this is the recent publication of a reproductive health guideline, with good and up-to-date norms on family planning care, but with chapters on adolescent reproductive health and birthing care that reflect a very medicalized approach and omit messages on more humanized birth procedures.

In summary, during the 1990s, some isolated improvements have taken place in a few universities in the pre-service training of medical doctors in family planning counseling and provision, thanks to USAID support and the work of dedicated individuals in these institutions. Broader changes in the teaching and practicing of reproductive health care will require a longer-term sustained effort.

3.2.3. Behavior Change Communication

During the period 1995-99, efforts were made to develop a set of messages and materials designed to promote FP/RH. The IEC/BCC materials developed for the PROQUALI initiative communications campaign adopted the Bahia program's slogan "Mulher é pra se cuidar", and comprised an exceptionally well-conceived integrated package of materials. The key message in the strategy largely reflects the thrust of the work done in FP/RH in Ceará and Bahia during this period: "Mulher é pra se cuidar" ("Women are worth caring for, and worth caring for themselves"). This expression reflects: 1) a will to put the client and her/his needs in focus; 2) that reproductive health is an issue for both women and men (and society, including health care providers); 3) that health is the issue, not disease nor demographic targets; and 4) to some extent, reproductive health is a rights issue. To a large extent, this key message, and the material and messages around it, reflects local implementation of the ICPD program of action.

The IEC/BCC materials include provider and client banners, tarot-like cards (each representing a contraceptive method), murals, videos, posters, five four-minute radio dramas of life stories of individual women who use different methods, street theatre, tee-shirts and hats, and health facility signs and plaques. Stocks of these excellent materials are already running low in Bahia and Ceará and will be needed for PROQUALI program expansion to other states. A set of camera-ready art has been made for each state (at SESA and SESAB) to facilitate frequent and inexpensive duplication. With modest adaptations, the materials also can be used for other reproductive health programs that are not PROQUALI-specific.

The communication strategies in Bahia and Ceará included training of journalists, a fax message service, and supporting secondary school students in developing and disseminating reproductive health messages via school journals. Overall, the mass media coverage of reproductive health topics, including TV and radio spots and programs, increased considerably during the late 1990s, and contributed effectively to other quality advances, such as facility-based improvements and increased client awareness and demands.

Without continuing support from USAID, local BCC initiatives were successfully initiated in parallel. One of the most striking is a weekly, one-hour TV program on reproductive health, produced in a major supermarket with the store's customers as participants. This talk show-like feature was initially sponsored by SESAB, then by the supermarket chain, and is now sponsored by companies whose products are shown/consumed on the program. Reportedly it is very popular with a weekly audience of one million viewers.

USAID-supported activities in the field of communication significantly contributed to the development and spread of holistic, client-oriented reproductive health messages via mass media and via health facilities.

3.2.4. Logistics Management

A significant qualitative improvement during Phase II of USAID assistance was the development, by Pathfinder, of a multi-purpose management information system (MIS) for reproductive health -- SISMAC. In Bahia, this automated Delphi-based software program allows the state health secretariat to receive monthly data on commodity logistics, service provision, and training from the municipalities. The data are used for monitoring, management decision-making, and planning purposes. Necessary hardware and systems training has reportedly been provided throughout Bahia. In Bahia, the system is presently used only for women's health programs, although it can be expanded for a broader health system use.

A parallel effort in developing a logistics management system took place in Ceará, assisted by MSH with BEMFAM software support. This Ceará system integrates contraceptive logistics management into the State Secretariat of Health's general pharmaceutical logistics system. Statewide training in this new system has not always received priority attention by the state health authorities. However, the statewide system was expected to be 94 percent completed by June 2000.

Experienced MOH officials had little faith in the information presently available to them on commodity flows between the federal, state, and municipal levels. They, therefore, requested that Pathfinder adapt the SISMAC program for use in monitoring the flow of contraceptives that they are now procuring and will distribute to all 27 states, as well as for monitoring service provision. The MOH also has requested Pathfinder to provide logistics training for personnel involved in contraceptive management and to assist in improving warehouse practices.

While both the SISMAC and Ceará logistics management systems are valuable improvements and are critical for ensuring program coherence and effectiveness, there appears to have been duplication of logistics systems supported by USAID. Since 1993, USAID, through its HIV/AIDS funds, has successfully supported efforts of the MOH's HIV/AIDS division to establish a national logistics management system for condoms and related commodities procured under World Bank loans. The Family Health Division of the MOH indicated that SISMAC will function as a stand-alone system and will not yet be integrated into other MOH-state monitoring and reporting systems.

3.2.5. Leadership Development

USAID also supported the design and initial implementation of an innovative Leadership Development Program for SESA, which has become entirely sustainable. The purpose of this program was to create a critical mass of public heath leaders for the state of Ceará, and focuses on developing professional and personal leadership competencies, of which improving the quality of public health services is an important part of the training. Begun in 1998, the program received applications from more than 400 state and municipal secretariat of health staff, of which 125 were selected. USAID provided funds to design the program and cover the initial training costs of the first 100 selected. At the end of initial training, participants prepare action plans; progress toward implementing these action plans is reviewed periodically during refresher training supported by SESA. The reproductive health, STD/AIDS, and Family Health Program

Coordinators participate in SESA's Leadership Development Program. With other donor funds, SESA intends to expand the program, to be called LeaderNet, beyond face-to-face training to include distance learning and other uses of technology to improve management performance.

3.3. State Initiatives

During Phase II (1992-2000) USAID support for FP/RH in Brazil , focused for the first time on specific states. Assistance was concentrated on the Northeastern states of Bahia (12.5 million inhabitants) and Ceará (seven million inhabitants). Both states are among the poorest of the 27 states in Brazil, which is reflected in the health indicators. Bahia and Ceará have benefited from stable political conditions during the 1990s, an important prerequisite for stable program development, with limited turnover in senior leadership.

In both states, the diverse program activities of the CAs were blended together and coordinated between 1995-2000 as USAID more effectively promoted the development of a common programmatic effort involving all CAs and their clients - the state secretariats of health. This blending led to the development of the PROQUALI program and its pilot operations in selected units.

USAID-funded activities undertaken with state health authorities include strategic planning (OPTIONS), management and leadership training (Management Sciences for Health - MSH), pre-service and in-service training, notably of doctors (JHPIEGO and Pathfinder), contraceptive procurement/logistics/ monitoring (Pathfinder and MSH), and behavior change communication (JHU/PCS). The situational analyses supported by the Population Council and MEASURE[34] as well as the DHS carried out by BEMFAM have been important for assessing family planning usage and provision in the two states. In addition, BEMFAM is actively and contractually involved in the provision of family planning services in many municipalities in both states, but at this level, works largely independent of the other CAs.

In both states, use of World Bank loans for buildings and infrastructure in the early 1990s eased the way for the development of health services.

3.3.1. Bahia

Family planning program efforts in Bahia have a long history, dating back to at least the 1970s when Pathfinder established a Brazil office in Salvador. These initiatives included efforts to incorporate family planning into medical curricula and to reinforce reproductive health initiatives targeted to adolescents.

During the early 1990s, the USAID-funded family planning program in Bahia contributed to the expanded provision of family planning, increased numbers of state and municipal health personnel trained in family planning, improved logistic management, and better provision of commodities. State-supported family planning services expanded from very low coverage in

[34] USAID program for collecting data, improving monitoring and evaluation of data collection, and disseminating information on population, health, and nutrition.

1992 to 50 percent of the municipalities and approximately 10 percent of the huge state's 3,000 health posts by 1999.

The percentage of service sites with all appropriate methods on hand (oral contraceptives, IUDs, and condoms) increased from 21-26 percent, according to situational analyses carried out in 1996 - approximately halfway through the Phase II period. Analysis by method showed an increase in the availability of oral contraceptives from 35 to 44 percent. Service sites with "health providers trained, adequate equipment, contraceptive commodities available, and consumable supplies," increased from 6 to 16 percent of health facilities. Fifty-three percent of clients interviewed at random when exiting service sites stated that they had perceived a positive change in the quality of care.[35]

Bahia became one of the first states to purchase contraceptives in 1995, and then successfully engaged municipalities in cost-sharing in 1999, spending over $1.7 million for contraceptives. Communication strategies and pre-service training, interventions summarized in Section 4.3.3, were given attention in the latter half of the 1990s.

From 1996 onward, the PROQUALI pilot program (designed for Bahia by MSH, JHPIEGO and JHU/PCS in collaboration with state authorities) became a central focus of the USAID program. PROQUALI was initiated in two pilot health posts during the testing phase from 1996 to September, 1998 and was expanded to an additional eight to ten posts in the initial expansion phase (Oct. 1998-Sept. 2000). Statewide management training, training of master COPE/TOQUES (Tecnica para Orientar a Qualidade e Eficiencia dos Servicos de Saude) facilitators, definition of quality service delivery criteria based on state guidelines, training of providers, communication activities to generate demand for and to promote quality services, and training and establishment of a PROQUALI Accreditation Committee were major accomplishments.

Cliente satisfeito, prefeito re-eleito " Satisfied client, re-elected mayor" is a phrase often heard these days in Bahia and Ceará around PROQUALI health centers.

Administrative reports from health posts in Bahia associated with the PROQUALI program indicate a substantial increase in the use of IUDs. However, these reports do not represent conditions in the state, including sterilizations conducted in secondary and private facilities. A more thorough assessment of the impact of key Phase II initiatives on reproductive outcomes is warranted, given the level of investment in and potential replicability of these interventions. The DHS 2001 survey currently being fielded by BEMFAM and the MOH offers an opportunity to examine these impacts; thought should be given to how follow-up analyses of impacts on key reproductive outcomes (method mix, service use, etc.) might be supported.

When the 2001 DHS is completed, the impact of this service expansion will be better understood. According to the results of the nationwide DHS carried out in 1991 and 1996, the proportion of all women between 15-49 years of age using contraception increased from 41 to 48 percent in Bahia. The method mix was still heavily dominated by two methods, the pill and

[35] "Final Report for USAID: Family Planning/Reproductive Health". The Population Council, p. 14.

female sterilization. A slight increase in the use of condoms (from 1 to 3 percent) and in other modern methods (from 2 to 4 percent) was observed. The unmet need for contraception in women aged 15-49 years declined from 11 to 9 percent.

Bahia's innovative FP/RH work in the early-to-mid 1990s was led by a few highly committed individuals who had strong political support. To some extent, this development effort has used a more vertical approach than in Ceará. Only in the late 1990s has the family planning work been merged with other reproductive health work (antenatal care and STDs) at the state level. This initial vertical approach has made the integration of FP/RH into other primary health care activities more difficult.

3.3.2. Ceará

The state of Ceará, although one of Brazil's poorest states, has a history of innovation among Latin American health programs. Its *Viva Criança* (Child Survival) program, implemented in the 1980s, received UNICEF recognition as a successful and replicable worldwide model. *Viva Criança* was followed by an innovative *Viva Mulher* program, supported by UNFPA from 1994 until 1999 with funds used primarily to properly equip reproductive health care facilities at health units, to purchase contraceptives, and to train supervisors. The MOH's Family Health Program, initiated in 1994, drew heavily on the Ceará *Viva Criança* model with family health teams and community health agents established to cover specific geographical areas.

Viva Mulher had a significant impact on the wider spread of family planning counseling and services. USAID support in Ceará nicely complemented UNFPA assistance, according to state officials, by focusing on program strategy, management and leadership development training, provider training (including at the largest medical school), development of a contraceptive logistics management system, and development of IEC programs and materials.

In Ceará, implementation of FP/RH overall has been somewhat slower than in Bahia, however, it has been integrated into the primary health care system in a solid and sustainable fashion. Full integration demands adaptation to local conditions, which takes time. The municipalization process is further advanced in Ceará than in Bahia. This also provides the basis for gradual, systematic expansion of family planning.

On the other hand, the slower uptake of new approaches perhaps leaves Ceará somewhat behind in the introduction of more recent interventions, i.e., the PROQUALI approach, which has been piloted for less than two years. PROQUALI was initiated in two facilities in the pilot phase (1996-98) and was expanded to 17 health facilities in nine municipalities (one micro-region and Fortaleza) in the initial expansion phase (1998-2000). The state hopes to expand the program to five more micro-regions (there are 21 micro-regions in Ceará) between 2000 and 2002. From the perspective of the state Secretariat of Health, the USAID phase-out after such a short introduction of PROQUALI raises concerns of sustainability.

Family planning services in Ceará improved during the first half of the 1990s. The number of service sites providing family planning services, already high, increased from 512 to 532 in 1997. The percentage of sites with all methods (oral, IUD, condom) on-hand remained stable at

11 percent when comparing 1997 with 1993 because condom availability decreased in health posts from 13 to 10 percent. The availability of oral contraceptives increased from 23 to 42 percent. IUD availability increased from 21 to 29 percent. The number of service sites with "health providers trained, adequate equipment, contraceptive commodities available and consumable supplies," did not change substantially (from eight percent in 1993 to nine percent in 1998) once again primarily due to decreased condom availability in some health posts. However, great improvement was noted in all other areas of preparedness since nearly all facilities had all other components (trained provider, equipment and consumable supplies). Of the clients interviewed, 53 percent perceived a quality improvement.

As in Bahia, there is a very limited evidence base in Ceará from which conclusions about USAID program results can be drawn for the period between 1996 and 2000. Most of the expected changes only were beginning to occur during the interval covered by the mid-program surveys and situational analyses. The 1996 DHS data show an increase from 34 to 43 percent in women aged 15-49 years using contraceptives between 1991 and 1996. Condom use increased from one to four percent, and modern methods other than pill/condom increased from one to two percent. The unmet need for contraception in women aged 15-49 years declined from 12 to 10 percent. The 2001 DHS will be valuable in demonstrating the impact of service expansion and quality improvement efforts in Ceará. While some inferences about inputs and their utilization can be drawn from state and national level information systems, and from discussions with providers at various levels of the system, these sources are fragmented and incomplete.

The availability of contraceptives in Ceará's health facilities continues to be a significant problem although a logistics information system has been designed with MSH and BEMFAM support and all municipalities reportedly will be trained in the program by September 2000. However as the writing of this report, SESA (the Ceará state health department) had not yet established a training unit needed to sustain PROQUALI management and other training.

In summary, in both Bahia and Ceará USAID family planning collaboration has contributed significantly to increased access to family planning counseling and services, and to systematic improvements in the quality of these services. The results of this two-state approach appear to be highly positive. They demonstrate, for example, how the PROQUALI model can be applied in states with very different state health structures, varying degrees of municipalization, and quite different program leadership characteristics. Potential donors for PROQUALI replication have more confidence in the program since it has been tested in two states.

Both states have managed to use the USAID family planning support for simultaneous improvement of other reproductive health services, albeit facing certain challenges when doing so. In both states, however, more needs to be done to make quality family planning services widely available. Without a doubt, much of the work, both as regards expansion and quality improvement, will be carried on after USAID support has been phased out as the Family Health Program expands.

3.4. Linkages to Other Health Interventions

USAID-supported programs have contributed to improved work in the prevention of HIV/AIDS in Bahia and Ceará, improved family planning counseling and provision, and to improved antenatal and STD care.

3.4.1. Maternal Health Care

Maternal mortality and the perinatal mortality rate (PNMR) are disproportionately high in Brazil, considering the overall health budget, GNP/per capita, and other health outcomes. Officially estimated at 59 maternal deaths per 100,000 live births, MOH officials informally estimate that the ratio is at least double that figure. Early neonatal mortality (deaths during the first week of life, which in Brazil constitute approximately half of PNMR) today constitutes a large proportion of infant and under-five mortality. The authorities recognize that reduction of PNMR is a major priority in Brazil, and this is reflected both in MOH plans, and upcoming World Bank lending to the health sector.

As indicated above, much of the PROQUALI work, and, to some extent, other work of the CAs in Ceará and Bahia, also addressed maternal health care. PROQUALI assumes a set of reproductive health interventions that has involved improvements in antenatal care, breast and cervical cancer screening, and STD care. The work on guidelines, norms, assessment criteria, and training has mainly focused on family planning, but has included breast and cervical cancer screening in Bahia, and antenatal care, breast and cervical cancer screening in Ceará. Although there was less emphasis on developing similar criteria and training to improve interventions in the non-family planning areas of reproductive health, the family planning program contributed to some improvement of maternal health care, notably of ANC, in Bahia and Ceará. Aspects of maternal health care also were addressed, via efforts to improve post-abortion care and pre-service training and curricula.

Today, postpartum visits are mainly carried out approximately 40 days after birth at the facility where the woman gives birth. Overall, this is a component that, evidently, receives little emphasis by the health care system. The postpartum visit does not appear to have been influenced greatly by the family planning program, and the timing also has not been optimal for family planning provision.

3.4.2. HIV/AIDS/STDs

Brazil has made a strong commitment to HIV/AIDS work, notably in innovative media strategies, peer group education for high-risk groups, and clear and generous strategies for the provision of antiretroviral drugs to the infected. Integration of preventive work into general family planning counseling and provision, into general STD work, and into ANC, has received relatively less attention in the past, but currently is being highlighted in the national AIDS program strategy. There is recognition, therefore, that more work must be done in this area, as part of public health care provision to the general population.

The USAID-funded family planning work in Ceará and Bahia has involved improvement in STD care, especially in the integrated PROQUALI model. However, less development work went into this area. In family planning counseling and provision, addressing STD and HIV risks are certainly part of efforts in training, norms and quality improvement. Condom use and dual protection were integrated and are important parts of the program.

So far, HIV testing is not routinely available in health facilities, but in every city and at a number of sites outside cities. To a woman receiving ANC in average public health facilities in Ceará and Bahia, a recommendation to get an HIV test during pregnancy necessitates a special visit to a testing facility. Only pre-counseling, done before the full voluntary counseling and HIV testing at the center providing the tests, takes place in the average ANC consultation. This naturally leads to less emphasis on HIV testing, and the majority of pregnant women receiving public reproductive health services in Ceará and Bahia are not tested for HIV.

More work needs to be done in this important area. PROQUALI provides a potential platform for quality improvement through which even better counseling and contraceptive provision can be achieved, with even more attention to STD and HIV prevention in individual talks or sessions with clients. Where STD care is provided in the same facility as FP/RH services, STD/HIV challenges remain high on the agenda by all staff. The increasing involvement of men, as partners and as clients in family planning, also is an important component in this preventive work.

USAID also continues to support other activities in the HIV/AIDS field: via support to state-level program managers in Bahia and Ceará, Rio de Janeiro, and São Paulo; via support for integration work at selected facilities in Bahia and Ceará; and via social marketing of condoms. The issues of integration mentioned above are, thus, priorities for USAID, and the sharing of experiences in this field among FP/RH/PROQUALI/National AIDS program will be important.

4.0. AREAS OF CONCERN

As summarized above, the Phase II program had very significant achievements during the 1990s; indeed, there have been simultaneous improvements of reproductive health quality and sustainability throughout all of Brazil during the decade. As one looks to the future, there are several areas of concern that should be addressed by the Government of Brazil (GOB) and donors. They are:

- the effective integration of family planning successes within reproductive health and family health initiatives, and as part of Brazil's ongoing health sector reform;
- the sustainability of the PROQUALI program in Bahia and Ceará without USAID support;
- the need for reproductive health services for adolescents and other underserved groups; and
- the inadequate provision of post-abortion family planning as part of reproductive health programs.

4.1. The Effective Integration of Family Planning Successes within Reproductive Health and Family Health Initiatives, and as Part of Brazil's Ongoing Health Sector Reform

USAID support for family planning in Bahia and Ceará brought about important developments that influenced certain other aspects of reproductive health. Thus, antenatal care, breast and cervical cancer screening, and to some extent, STD care improved due to the USAID support. Other areas, such as domestic violence, delivery care, and HIV/AIDS received limited attention as components of USAID's FP/RH strategy, although USAID/Brazil does have a separate HIV/AIDS program. As a result, a challenge remains to fully integrate family planning work and its experience into reproductive health work overall, and to continue expansion in coverage and quality.

As illustrated by the ICPD and by this program, client-centered, quality reproductive health services, rather than demographically motivated quantitative approaches are clearly the road to improved uptake. This is also the strategy of the GOB, which increases the possibility for GOB funding. It also is the approach emphasized by women's health advocates. Finally, health sector reform requires consolidated reproductive health efforts to retain victories won and facilitate further improvements.

For true impact on reproductive health status, improvements are needed in different levels of care (peripheral public facility, private practitioner, hospital care), via different channels (care provided, teaching of medical students, normative work, policy), as well as interventions outside the health sector (adolescents in and out of school).

Currently, the process of municipalization requires much attention. Losing important health gains during the transition of health care provision responsibility from relatively strong state administrations to the sometimes quite small municipalities must be avoided. Experiments are ongoing with the development of "micro-regions" that will address certain issues for a group of smaller municipalities. The municipalities, or micro-regions that have chosen full

municipalization – including administration or contracting of local hospitals – possibly will have relatively less managerial capacity to improve primary health care. Such administrative and coordinating challenges will take time to resolve. In the meantime, the coordinating and normative role of the state level administration will be exceedingly important for the continuation of improvements in reproductive health.

Over the past few years Brazil has initiated a rapid expansion of the FHP. The program is based on health centers providing not only health services but also serving as a social reference center to the low income population in the catchment area. Health services offered include family planning, prenatal care, cancer prevention, heart disease, diabetes, STD/HIV/AIDS prevention, small surgeries and others. The health center is responsible for an average of 4,000 in its catchment area. In principle, a team consisting of a family physician, a nurse, a nurse auxiliary and a few community health workers are the primary caregivers and health promoters for a defined group of families. For the long term, it is planned that such teams also will act as gatekeepers for referrals to higher levels of care. The transition to such a system of primary, area-based family health care is a major change in Brazil's currently highly medicalized, specialized, pluralistic, and doctor-dominated health care network. The stark inequities of the current situation and the perceived impossibilities of simply expanding this medicalized, top-heavy system are the driving forces behind the thrust towards the FHP.

At the university level, major changes are needed both in the basic medical and nursing curricula, and in the specialization required for family physicians. Changes in curricula need to be accompanied by practice periods in the community, i.e., medical students seeing more unselected out-patients rather than selected cases of severe disease, and an increased role for the units that teach public health and family health. The whole orientation of the work of medical schools eventually will change with such a paradigm shift. Also, but not less important, is the challenge of shifting significant resources from hospital care to primary health care. So far, the expansion of FHP units has been getting strong support. The units that have been evaluated show a drastically increased uptake of basic health care (antenatal care, tetanus vaccination, etc.). Naturally, safeguarding and expanding reproductive health care will require a smooth transition of experiences gained. The potential role of external funds to facilitate this transition is discussed below.

How the municipalization and the transition to Programa de Saude Familiar (PSF) eventually will change the pattern of health care provision in Brazil remains to be seen. Whatever happens, the challenge to reach private practitioners providing reproductive health care will remain, as well as to address the different levels of care in the chain – primary care and hospital care. This program clearly illustrates how caregivers at these separate levels, be they public or private, have a joint influence on reproductive health. Family planning is provided not only at the primary level, but also in hospitals in connection with post-abortion and postpartum care. The influence of private doctors is enormous. Even more, the challenge of improving maternal and perinatal mortality – current concerns in Brazil – will require strong, coordinated efforts to improve both coverage and quality via these different delivery points.

USAID support has contributed to improved access to quality family planning services in Bahia and Ceará and, in so doing, has contributed to improvements of other reproductive health

services at the primary level. Due to structural challenges in the existing health system, it has been more difficult to improve family planning-related care at the hospital level. The PROQUALI model is a promising strategy to improve reproductive health, in general, and other primary health care functions at facility level in the FHP.

4.2. The Sustainability of the PROQUALI Pilot Program in Bahia and Ceará without USAID Support

Although USAID support focused on the states of Bahia and Ceará since 1992, the most promising program initiative developed -- PROQUALI -- was designed in late 1996 and has had less than four years of implementation.

Two health facilities in Bahia were included in the PROQUALI design and testing phase from September 1996 through September 1998. The initial expansion phase, from October 1998-September 2000 expanded the number of PROQUALI facilities to 13. The situation is similar in Ceará with two posts included in the pilot phase and 14 posts in nine municipalities (eight aggregated into one micro-region in addition to the municipality of Fortaleza) included in the second phase. Although both states have plans for statewide expansion (Ceará would add five micro-regions to their total 16 micro-regions every two years) the PROQUALI nucleus is still quite small and fragile.

Most of the planning and initial development costs of the PROQUALI program already have been invested and need not be repeated. The program methodology has been developed and tested, training guides have been prepared, operational guidelines for services have been written and disseminated, and the first PROQUALI training and quality improvement teams have been trained. The "running costs" of the PROQUALI program are modest - mostly extra staff expenses, training, and travel per diems, along with some basic infrastructure improvements in newly participating health facilities. The costs of improving clinic infrastructure (e.g. paint, functioning bathrooms, some new equipment, chairs, etc.), were all paid by the municipalities in the pilot phase (even in relatively poor rural areas), and probably should continue to be a local contribution to the PROQUALI program.

While health leaders in both states indicate commitment to PROQUALI and a strong willingness to expand the program even without additional outside assistance, several key outside inputs have been identified by these states as necessary for rapid PROQUALI expansion. These include:

- increasing the core group of qualified state-level trainers (“Grupo Tecnico”) that are needed to make up a larger number of PROQUALI training teams. In Ceará a SESA training group has not yet been established;
- financing the costs of maintaining PROQUALI accreditation committees (special, part-time committees largely composed of university specialists);
- periodic technical assistance to provide outside guidance for the training of trainers process, and for problem resolution;
- technical assistance to assist with periodic evaluation and adjustment of the PROQUALI process;

- completion of PROQUALI distance learning programs for health professionals in both states;
- funds for the reproduction in much greater quantities of the excellent PROQUALI IEC materials; and
- improvement of weak state supervision systems.

In sum, neither state has developed a sufficiently large "core PROQUALI" program to ensure rapid statewide program expansion or to develop a large constituency base. Although neighboring health facilities and personnel are clearly being "infected" by the PROQUALI contagion and want to join in the PROQUALI program, both SESAB and SESA have significant limitations on how fast they can lead the expansion process without outside technical and financial assistance.

4.3. The Need for Reproductive Health Services for Adolescents and Other Underserved Groups

4.3.1. Adolescents

During the 1990s, pregnancy rates in adolescents increased significantly both in Ceará and Bahia. Sexual debut is now on average earlier; moreover, when comparing the DHS data of 1991 to those of 1996, a higher proportion of adolescent pregnancies were unwanted. This is of great concern, even more so in the light of the growing HIV/AIDS pandemic. The causes behind these behavioral changes are multiple, but the significant increase in adolescent unwanted pregnancy, as such, raises the need for educational outreach programs to more systematically target adolescents than has been the case in the last decade. There are currently a growing number of federal and state initiatives in this important area.

USAID support to family planning in Ceará and Bahia included, but did not prioritize, contraceptive information, counseling, and provision for adolescents. Teenagers, particularly girls, were frequent visitors at educational sessions and as contraceptive clients. The improved communication skills of staff interested in adolescents contributed to improved access for adolescents in some health facilities. Some educational activities specifically targeted adolescents but there was no particular emphasis in this area in the USAID family planning program.

USAID-funded programs addressing the problems of HIV/AIDS and "At-Risk Youth" did address the reproductive health needs of adolescents in both Bahia and Ceará. The POMMAR program, carried out through NGOs, is seeking collaboration with state health facilities to improve reproductive health care provision for youth. The lack of special attention, and consequently resources, dedicated to adolescent health by official state programs reportedly makes linking these efforts difficult.

During the last 10 years, the national discourse on issues related to FP/RH has changed enormously, influenced by political change, the ICPD, the AIDS epidemic, urbanization, economic growth, and increased access to mass media. The general attitude toward a number of family planning questions is, thus, very different today than in 1990, and this certainly is inter-

connected with the messages communicated by health care providers and educators. Brazilian initiatives in peer group education for high-risk groups, such as commercial sex workers or street children, also are well-known and appreciated internationally.

It must be remembered, however, that the changes in discourse are fairly recent, and that traditional values, including religion, are still strong in Brazil. Several spokespersons mentioned that the average capacity among health care providers or educators to discuss the intimate issues of sexuality at an individual or small group level is still quite limited. Being able to discuss such issues with clients or students is demanding, and requires experience and self-insight. In Bahia, distance learning materials on sexual and reproductive health have been developed by NGOs for use by teachers. However, it is questionable how much of this new knowledge is available to teachers and students. In a few instances, FP/RH approaches for adolescents in health facilities have been planned in connection with systematic contacts with the schools close by, linking educational efforts to health service provision. Evidently, this has been more the exception than the rule.

In summary, given the severity of adolescent reproductive health problems in Brazil, greater attention will be needed in the future to the linkage between FP/RH, HIV/AIDS, and other programs to more systematically target adolescents. More flexibility and greater attention to adolescents by USAID over the course of Phase II could have facilitated intensified work in this area, as it was gradually recognized that adolescent reproductive health was becoming a growing priority.

4.3.2. Underserved Groups

With the gradual expansion in family planning services in Bahia, Ceará, and several other Northeastern states, and with the broadening of contraceptive choice, some groups have been left behind. In future FP/RH programs they will need special attention. Apart from the major challenge in adolescent reproductive health, mentioned above, there are large underserved groups of poor people in cities and in rural areas. The Northern states face a major challenge in this regard, as areas where health care is effectively unavailable are much larger than in peripheral Bahia and Ceará. It only can be hoped that family planning expansion will reach these groups more effectively with the FHP. BEMFAM, in the coming years, has a potentially important role in these presently grossly underserved areas.

Another challenge is that of reaching men. In Brazil, as everywhere else in the world, FP/RH are often seen as women's issues; involving men to a larger extent will require special efforts. The campaign "Mulher é pra se cuidar" seems to have had a very positive effect, putting the value and care of women's health in focus, but it also has engaged the support of men. The 1998 family planning law finally legalizes vasectomy (which, like tubal ligation, has been generally accepted within Brazilian medical practice) and, therefore, should encourage expansion of the male-oriented family planning activities begun through the USAID-funded PROPATER programs of the 1980s. Much work still needs to be done to increase male involvement in reproductive health.

4.4. The General Absence of Adequate Post-Abortion Family Planning as a Part of Reproductive Health Programs.

It is well-known that in Latin America, including Brazil, a large proportion of women who seek health care for "spontaneous abortion" actually have had an illegally induced abortion. It was agreed at the ICPD that, whatever the cause of the abortion (spontaneous or induced), women seeking care after abortion require non-discriminatory care, adequate medical treatment, and contraceptive counseling and provision. Systematic efforts have been carried out in Brazil, including Ceará and Bahia, to fulfill these recommendations. It is widely recognized that many women seeking post-abortion care have failed in their contraceptive efforts and need help to prevent similar situations occurring.

It was difficult to ascertain whether any significant and sustainable improvement in post-abortion family planning had taken place in the project area during the 1990s, although this was a key Pathfinder program area during Phase I. Clearly, many women in the project area do not receive any family planning provision in direct connection with post-abortion care. The existing health system structure, with remuneration and supply issues as determinants, appears to impede the continuous provision of such services at present. The fact that post-abortion care is provided (or should be provided) at the hospital level also may explain why this issue is more difficult to deal with than improving outpatient family planning services at the primary health care level. Post-abortion care demands more of the system. Without indicating blame in any particular direction, a significant improvement in routine post-abortion family planning remains a public health challenge in Bahia and Ceará.

It also should be noted that, in spite of Brazilian law permitting induced abortions on limited indications such as severe maternal health problems, only seven of the twenty-seven states presently have any public facility caring for the few abortions permitted under this clause. Thus, for women residing in other states, having access to legal abortion largely depends on financial status.

5.0. PROGRAM ELEMENTS THAT SHOULD BE REPLICATED OR SUSTAINED

5.1. Priorities for Replication

Several key program elements are "proven" and should be replicated beyond their present geographical limits. These include:

a) PROQUALI is an excellent model that is ready for replication beyond Bahia and Ceará. The neighboring states of Rio Grande do Norte and Sergipe already have indicated considerable interest in adopting this program. A new NGO is being established in Bahia to, *inter alia*, help expand PROQUALI to new states, but funding for program expansion needs to be secured. The expansion of PROQUALI within Bahia and Ceará also will require some outside support;

b) The SISMAC management and logistics information system developed for Bahia is an excellent integrated MIS that would be valuable for other state health systems. As noted above, one element of the SISMAC system -- the logistics management module -- apparently is being adopted by the MOH for planning and monitoring the need for contraceptives currently being procured by the MOH;

c) The IEC/BCC materials developed for the PROQUALI initiative communications campaign with the slogan "Mulher é pra se cuidar", comprise an unusually well-conceived integrated package of materials. It includes provider and client banners, tarot-like cards (each representing a contraceptive method), murals, posters, five four-minute radio dramas of life stories of individual women who use different methods, street theatre, tee-shirts and hats, and health facility signs and plaques. Stocks of these excellent color materials already are running low in Bahia and Ceará and also will be needed for PROQUALI program expansion to other states. With modest adaptations, the materials also can be used for other reproductive health programs that are not PROQUALI-specific; and

d) BEMFAM's *convenio* support for reproductive health delivery systems in underserved states is a proven service delivery system that continues to be in demand and paid for by municipalities in almost all the Northeastern states. BEMFAM *convenio* services probably would be extremely valuable in the underserved North and Central-West regions as well (especially the more remote states), but BEMFAM would need an infusion of outside funds to expand their newly self-sufficient program to any new states.

5.2. Priorities for Sustainability

At least two key program areas appear to require future attention to ensure their sustainability. The first is continued financial support for DHS and other related demographic research and data development. Although BEMFAM now has the research and analytical experience and skills to lead future DHS surveys in Brazil, these surveys must be funded by the MOH or by donors/foundations on a systematic basis.

Second, operational research on new and existing contraceptive methods has been carried out in Brazil with the leadership and support of the Population Council. While the Population Council intends to retain its office and continue its operations in Brazil, donor and/or foundation support may be needed for new research initiatives.

6.0. OPPORTUNITIES FOR FUTURE INVESTMENTS IN BRAZIL' S REPRODUCTIVE HEALTH PROGRAMS

6.1. World Bank/Inter-American Development Bank

World Bank loans to Brazil are currently supporting two major initiatives in health: the health reform process under REFORSUS (jointly with the InterAmerican Development Bank (IDB)) and the national AIDS program. While the REFORSUS program is focused mainly on the secondary and tertiary levels of care, it is supporting the 2001 DHS-type survey. The Bank is currently considering further lending that will focus on primary care and support the FHP. Potentially, both could provide support for expanding the PROQUALI program in Bahia and Ceará, as well as replicated in other states. In fact, the first loan will be for Bahia state, and will finance improvements in the state's health system, including some experimentation with private involvement in service delivery. In addition, loan funds will be used for technical support to the sub-regional and municipal health secretariats, improved capacity to deliver maternal and child health services, and an incentive fund that will enable selected regions to carry out innovative programs. A similar incentive fund already exists under REFORSUS. The Bahia project is expected to go to the Bank's Board sometime later in calendar 2000. Also in the pipeline is a national level loan to support expansion of the FHP. The major features of this very large loan were still under discussion at the writing of this report, but it is likely that it, too, would have an incentive fund similar to the ones described above.

Quality of service delivery has been tagged as a major concern in the discussions for both loans, providing a clear opportunity for the states to seek support for expanding the PROQUALI program with resources from these loans. For that to happen, state officials and CAs that have helped to design and launch PROQUALI will need to engage their counterparts at the state and national level working on the FHP to show them how PROQUALI works and what its potential is for improving the quality of primary health care under the FHP. The packaging of PROQUALI for these audiences will require emphasis on broader themes than those covered so far for audiences familiar with PROQUALI and USAID. The FHP people are interested in primary care in general and not just FP/RH.

While presentations at the May 2000 CAs meeting in Salvador emphasized that PROQUALI can, in fact, deal with the full range of primary care services, which was confirmed during site visits to municipal health posts participating in PROQUALI, much of the documentation uses examples from FP/RH. It will be important to convey to state and national audiences outside the PROQUALI circle that it can be a model for improving the quality of overall primary care as envisioned in the FHP. This may entail developing additional examples of how PROQUALI has contributed to quality improvements, and ensuring a broader emphasis on primary care materials that are prepared for communicating with those audiences.

The Family Health Program: Brazil's FHP was established in 1994 in an effort to strengthen primary health during the period when the decentralization process, initiated under the Unified Health System (SUS), was being implemented. Most of the focus during the early years of SUS was on the secondary and tertiary care levels. As greater responsibility for primary care was passed to municipalities, the Government recognized a need for greater focus on primary care. Also, the financial crisis of the late 1980s and early 1990s was making it difficult for municipalities to provide the basic care guaranteed to Brazilians by the 1988 Constitution. This helped to focus attention on improving municipal financing mechanisms.

The centerpieces of the FHP are (a) a capitation system providing municipalities with financing for primary care and (b) a municipal-level health team consisting of a doctor, a nurse, and a nurse's assistant, who work in tandem with a team of community health agents to provide their service area with a basic service package that includes pre-natal care, FP/RH care, child health care, control of infectious diseases, and adult health care. The FHP takes a broad approach to primary care; it involves the community in health activities, identifies and seeks to mitigate risk factors, and emphasizes health education and health promotion. The MOH's FHP supports training, certification, and technical support to municipalities. Municipalities that participate in the FHP are entitled to special financial incentives.

The current Minister of Health has made FHP a high-profile initiative, and has included it in the National Development Plan (Avanca, Brasil). The goal is to expand coverage to 50 percent of the population by 2002 (coverage in 1999 was estimated to be approximately 20 percent). The Government has submitted a project concept paper to the World Bank for a large loan to support this expansion; the World Bank expects to begin preparations for this lending by mid-2000.

One issue that may affect the capacity to tap these resources for expansion and replication of PROQUALI is the timing of the loan approval and effectiveness process. If the Bahia loan is approved this calendar year, incentive funds might become available in the first half of calendar year 2001. Plans for the FHP loan are still evolving, with the hope that it would go to the Bank Board before June 2001. It is unlikely that resources would be available until late in calendar year 2001. The possibility of securing support from the REFORSUS incentive fund should be explored.

The IDB is presently co-financing REFORSUS along with the World Bank with the latter taking the lead to provide technical and operational oversight for this program. Other programs presently being supported by the IDB include a pilot maternal mortality program ("Santas Casas de Misericordia"), and training of nurse auxiliaries.

6.2. Smaller Donors and Foundations

The number of smaller donors (bilateral and UN agencies) and foundations that fund specific elements of reproductive health programs in Brazil has always been small. Unfortunately, the most consistent donor over the years (UNFPA) is now considering whether to close its program

in Brazil. This is particularly untimely since UNFPA had begun to finance a pilot expansion of PROQUALI in Rio Grande do Norte, an expansion that is presently on hold and without funding. UNFPA has been a source of funds in the past for demographic and operational research, so their departure, if it occurs, would represent a significant loss for that sector.

UNICEF continues its small but very effective program in Brazil. Its program priorities are presently "rights-based programs," early childhood development, and child labor. UNICEF does not presently place a high priority on health or reproductive health.

The Japanese International Cooperating Agency (JICA) is a recent arrival as a bilateral donor working in the reproductive health sector in Brazil. Its major health programs are "Projeto Luz," a safe motherhood program that works in nine municipalities in Ceará, and support for Casas de Parto in São Paulo.

The Ford Foundation has a long history of support for a variety of reproductive health programs in Brazil, including initial support for BEMFAM and Pathfinder. Since the 1980s, Ford has funded a variety of small demographic and operational research activities, and provided timely support for the growing women's movement.

7.0. LESSONS LEARNED

The states, NGOs, CAs, and USAID were all asked to reflect on the Phase II program period and provide key "lessons learned" from their experience. These lessons are aggregated and summarized below.

7.1. Initial Program Planning

- At the strategic level, the mix of national and state level program components within a sectoral context had synergistic impact and brought broader change than would have been achieved if the USAID program had concentrated all its resources only on state level activities or on nationwide activities. For example, national level research helped to define state-level actions, and state and local level program realities helped identify national policy issues;

- Because initial program planning, for example at the state level, takes time and requires a good deal of donor and CA flexibility, donor program priorities should be shared among the donor partners. For the Phase II program, collaboration became much easier, and USAID-funded CAs worked better together when they combined their efforts to consummate a clearly defined program idea such as PROQUALI. Prior to PROQUALI, one Ceará official stated that s/he didn't understand the USAID program terminology and didn't grasp what the USAID program was trying to achieve;[36]

- During the implementation period, it is essential to have the participation of all key partners in evaluations of progress and their collaborative participation in decisions to modify program objectives and strategies. USAID's annual meeting with all stakeholders was a valuable tool to clarify and reinforce overall program objectives; and

- At the local level, involving local community leaders in planning proved to be invaluable for program appropriateness and sustainability. Requiring local partners to invest their own resources as the local counterpart in a program is important. This was done successfully when even poor, rural municipalities in Bahia and Ceará paid for the physical improvements in PROQUALI health posts. Planners must also consider the financial limitations of these local entities that, for example, never could finance the clinical equipment for reproductive health units that was provided by UNFPA in Ceará as part of the *Viva Mulher* program.

[36] That is, until PROQUALI was initiated as a “program” approach that all of the USAID-funded CAs jointly supported, this Ceará official saw the USAID-funded activities as isolated interventions, carried out by individual CAs acting on their own, rather than as part of a broader, well-conceived joint program.

7.2. Evaluation

- The program evaluation system, complete with indicators, needs to be spelled out at the beginning of the project;

- Data analysis activities should not be planned and carried out only by technical and operational personnel. The results are more often used for future planning when some program and policy personnel, in addition to technical specialists, are included in the initial planning phase and kept informed throughout the analysis; and

- A balance is needed between the level of information a donor needs to monitor the implementation and results of its program, and not overburdening project partners with heavy or unrealistic reporting requirements.

7.3. Leadership

- Leadership (especially the roles of state coordinator and health center managers) is critical to program success. Leadership can be taught in leadership development courses, it is not simply "found". Strengthened leaders can mobilize resources. They need to focus attention on the political, as well as the technical level;

- Leadership is needed to constantly maintain motivation at all levels during the accreditation process; and

- Leadership also must be found when donors work with the private sector. In the case of the failed UNIMED collaboration, the USAID CA quickly identified a private sector organization and leaders within it to carry out an innovative pilot program. When the pilot program faced difficulties, these leaders lacked the corporate power and long-term commitment to convince the corporation to continue the program.

7.4. Recognition

- External recognition helps motivate local actors. Positive press coverage is valuable and stimulates both providers and clients;

- Accreditation is key to performance and quality improvement; and

- Incentives, monetary or non-monetary as appropriate, should be identified for rewarding improved performance.

7.5. Quality in the Public Sector

- The public sector can respond to demands for better services if given the means;

- The improved quality of reproductive health services is "infectious" and leads to improvements in the quality of all public health services at many health posts. The reform process strengthens and motivates the whole health team;

- Quality can be defined, put into practice, and measured. Developing service norms and guidelines helps clearly define the functions of different providers and creates opportunities for changes and expansion of functions; and

- Quality improvement requires leadership, a team approach, and involves community, clients, and all levels of staff. All staff must agree with the concept of service quality.

7.6. Training

- Long-term investment in training and skill-building is now visible in most key program performers. Invest in local talent, outsiders don't stay;

- In spite of some cost limitations, in-service training has been demonstrated to be effective in transferring new skills and knowledge. Train on-site, monitor, and follow-up with additional training;

- The rotation of staff, both trainers and trainees, is a significant limiting factor in the success of training programs for service providers; and

- Competency-based training at medical schools creates a demand for institutional accreditation and professional certification.

7.7. Sustainability

- The process of sustainability (for an organization such as BEMFAM) requires strategic management changes, as well as changes of behavior and attitudes throughout an organization;

- Sufficient supplies of all contraceptive methods are key to sustained service delivery, more important than other input areas. A gradual, clearly planned phase-out of donor-provided contraceptives can work successfully. In the Brazil case, organizations other than USAID did eventually provide funding for contraceptives when they were given a reasonable time for transition;

- The long-term sustainability of donor-funded family planning program activities requires that they be "marketed" in a broader context (e.g., within a state's reproductive health program or the GOB's Family Health Program) even while they are still trying to achieve

relatively narrow family planning targets. This means building bridges to key actors at the state and national level who may be considered "clients" during the project design stage, but who will be key players when the time comes to seek further funding to sustain program activities; and

- Sustaining quality depends on continued effective client demand.

ANNEX A
SCOPE OF WORK FOR
FINAL REPORT ON FP/RH ASSISTANCE TO BRAZIL

Background: USAID assistance to Brazil for family planning will end Sept.30, 2000. Both USAID/Brazil and USAID/W are interested in a final report documenting USAID's contributions, accomplishments of the Brazil program, and lessons learned, particularly over the most recent strategy period 1992-2000. Previous evaluations and assessments have described earlier periods of assistance and should serve as reference documents and background for this final report.

The CAs currently working in Brazil (MSH/FPMD, JHU/CCP/PCS, JHPIEGO, CMS, The Population Council, MEASURE//Evaluation, Pathfinder, FHI), BEMFAM, and the Secretariats of Health in Bahia and Ceará will be asked to prepare final reports of their own, following an outline provided by USAID. These individual CA/partner reports will be a principal source of data for the team, together with personal interviews, and review of documents.

General outline of the report:
Introduction -- context; history of USAID assistance; trends in FP/RH
1992-2000 period -- strategy; CA perspectives; partner perspectives
Policy issues and changes
Program accomplishments
Lessons learned

USAID would like to have both a full report and a shorter policy document that can be widely circulated in Brazil (in Portuguese), in USAID/W, and to other audiences as appropriate. The policy document should be no more than 20 pages in length.

Proposed process:
USAID/Brazil and G/PHN/POP propose a joint effort between POPTECH and MEASURE/Communication. POPTECH would be principally responsible for the full report; MEASURE/Communication for the policy document. In order to facilitate the preparation of the policy document, we suggest that the MEASURE/Communication staff member or consultant be a member of the POPTECH team that develops the full report.

Schedule:
A Brazil CAs meeting is scheduled for late March 2000. The CA/partner reports will be in final form and available to POPTECH shortly before the meeting (e.g., March 15). The CA meeting will be organized around presentation and discussion of the final reports and the POPTECH team should plan to attend the meeting. The team may want to arrive in Brazil before the meeting and/or stay afterwards in order to conduct interviews and do other data collection.

The POPTECH Report and MEASURE/Communication policy document should be completed by July. Dissemination of the report in Brazil should happen between July-September 2000. Dissemination in AID/W can occur on a less fixed schedule.

Next steps:

The Brazil Team requests that POPTECH and MEASURE/Communication prepare budgets for this activity assuming:

- a 2- to 3-person team, including one person from MEASURE/Communication;
- a 3-week trip to Brazil
- preparation of a final report (POPTECH), and a 20-page policy document (M/Communication)
- translation of the policy document into Portuguese (M/Communication)
- dissemination (MEASURE/Communication should propose a dissemination plan for Brazil and USAID/W).

ANNEX C
BRAZIL AS A MODEL FOR USAID PHASE-OUT STRATEGY

The following review of the results of the Brazil phase-out strategy for the USAID family planning program might provide some useful lessons for future USAID strategies.

The Setting: The "givens" for this phase-out strategy were budget and personnel levels. It was clear that annual funding for the FY93-00 program period was likely to be approximately $5-8 million. The USAID/Brazil program was not based on a bilateral relationship with the GOB due to Brazil's non-compliance with the Nuclear Non-proliferation Treaty and its unpaid Brooke Amendment debt to the U.S. Therefore all funding for the Brazil program was obligated through USAID/W Global Bureau Cooperative Agreements. This eased the administrative burden on Mission staff and contributed to a decision to keep the size of the Mission staff quite small. Through the phase-out period the USAID Mission had only two USAID direct hire employees and a limited number (7-12) of Brazilian professional staff working on all programs. From late 1992 to 1997, one of the U.S. direct hires was a PHN officer who had primary responsibility for the management of the family planning program (as well as HIV/AIDS and an At-Risk Youth program). Throughout this period, the PHN officer had the support of only one Brazilian professional.

Strategic Program Decisions: Length of the Phase-Out Period: The eight-year phase-out period was relatively lengthy. For CAs already working in the Northeast such as BEMFAM and Pathfinder, it seemed to give considerable time to work towards program phase-out and program sustainability. However, for CAs just beginning their activities in the Northeast in the 1990s, the eight year period was a relatively short period to start-up, consolidate, and turn-over their program activities. BEMFAM needed all of this lengthy period to achieve nearly full financial sustainability, in part, due to initial resistance from BEMFAM leadership and IPPF to believe that a "phase-out' would really take place. However, BEMFAM now expects to be 91 percent self-sustainable in 2000. Pathfinder's Brazil office, on the other hand, quickly developed a USAID family planning phase-out plan, began to diversify its program mix to include HIV/AIDS and environment activities, and initiated a search for other funding sources.

For the states of Bahia and Ceará, the eight-year period appeared to be adequate until the PROQUALI initiative started in 1996. The development of this late, but very important quality initiative created a dilemma. Should USAID provide assistance to PROQUALI for only a short pilot period while continuing its planned program phase-out in 2000 without any exceptions, or should PROQUALI be fully supported by USAID through both the initial pilot phase and a first expansion phase in both Bahia and Ceará - through 2001 - in order to strengthen its long-term sustainability in those states? The USAID decision to terminate support for PROQUALI at the planned phase-out date of September 2000, but after only four years of implementation, meant that these two states and the PROQUALI CAs had to focus on program development and program sustainability almost simultaneously.

Since the ultimate "results" and the sustainability of the PROQUALI initiative are still clearly open to question, due to its short length of implementation, the ultimate wisdom of this USAID phase-out decision will depend on whether the PROQUALI concept and the programs in Bahia

and Ceará can quickly attract funds from other donors. If the PROQUALI concept is not included as part of the new MOH/World Bank family health loan, there is a reasonable chance that this exciting new initiative will falter and USAID's decision to complete its orderly phase-out without any exceptions will prove to have been incorrect.

USAID Technical Officers Do Make a Difference: USAID/Brazil PHN officers were responsible for three critical decisions that helped make this strategy more successful, according to several informants. 1) "Opening Closed Doors": Beginning in 1993, the PHN officer carried out a consistent strategy of initiating contact with Brazilian women's organizations, previously hostile to USAID's family planning program, and discussing the components of the new Phase II strategy with them. This dialogue eventually led to USAID financial support for several women's organizations participating in Cairo ICPD conference and a much healthier dialogue between USAID CAs and the women's organizations; 2) "Insisting Upon CA Cooperation": In 1995, the newly arrived PHN officer met with all of the USAID-funded CAs working in Bahia and Ceará and insisted that they quickly develop a more coherent joint program strategy. This meeting, following on the mid-term evaluation, was reportedly decisive in starting a strategic planning process that resulted in the PROQUALI initiative; 3) "Finding Critical Program Funding": In May 1998, BEMFAM needed additional funds to launch a major promotion campaign for its new PROSEX condom, the linchpin of its financial sustainability strategy. Against the strong counsel of more experienced USAID officers, the Brazilian PHN assistant insisted on traveling to USAID/W with the BEMFAM social marketing director to make the case for additional funding for this promotion campaign. Their presentations were extremely effective and USAID received $415,000 for the BEMFAM campaign a month later.

The Two-State Strategy: The USAID phase-out strategy elected to put its focus on only two of Brazil's 27 states following USAID/W guidance to "focus and concentrate" all USAID programs in the face of diminishing annual appropriations. The two states chosen were in Brazil's poorest region and the region with the worst family planning indicators. Given the size of USAID family planning funding for Brazil and the need to finance several national level activities, program funding for these two states is estimated at about $4 million/year ($2 million per state) — not a high level for such large states, especially when one subtracts the cost of CA overhead rates. Inclusion of a third state would have provided another opportunity for a successful outcome, but also would have reduced the funds available for each state program. Concentrating on a single state would have put all of USAID's "eggs in one basket", a considerable risk since USAID had no prior experience working heavily with any state bureaucracy as part of its family planning program in Brazil.

Among the nine Northeastern states, Bahia and Ceará are among the largest, with a combined population of 16 million (larger than many countries in Latin America). Ceará had a positive history of health reform as the site of the innovative Viva Criança program that successfully introduced community health workers and radically reduced infant mortality in only a few years. The Bahia state government, on the other hand, was not particularly known as a health innovator. But a strong Bahian leader for a growing family planning program had been identified by one of the CAs and high-level political support for the USAID program was anticipated.

The results of this two-state approach are highly positive. They demonstrate, for example, how the PROQUALI model can be applied in states with very different state health structures, varying degrees of municipalization, and quite different program leadership characteristics. Also,

potential donors for PROQUALI replication have more confidence in the program since it has been tested in two states.

Program Components: The USAID/Brazil program included a focus on two states, a regional delivery system program (BEMFAM in the Northeast), and several national elements (data collection/dissemination, policy, increased choice of contraceptive methods, and private sector initiatives). This report summarizes significant achievements in each of these components, achievements that are not isolated but affect other elements of the program (e.g., DHS use in Bahia and Ceará). Although changes in the relative weight of the program components might have brought stronger returns, in general, the original strategic mix was good. The strategy also was flexible, adding a major management component after the 1995 mid-term program evaluation. Funding was reduced for private sector initiatives after the relatively poor performance of the PROFIT project, a decision that may have limited the ultimate impact of the program on the commercial sector.

CA Collaboration Strategies in the Two States: The initial USAID strategy placed responsibility for CA state level coordination in the hands of a lead CA. Pathfinder was chosen as the lead CA in Bahia due to its long presence there and its close ties with the Bahian program leadership. An individual was hired on a part-time basis in Ceará where there was no obvious choice for a lead CA. He was a respected U.S. health professional living in Ceará who had wide and positive ties with government health professionals.

The lead CA concept did not work well in either state even though a considerable effort was made in 1993 to develop comprehensive state plans with the participation of the state health leaders and all of the CAs. Pathfinder was not always viewed as being open and even-handed in working with other CAs in Bahia, and the individual in Ceará often was absent and did not have the authority or USAID-related experience needed to direct the CAs effectively.

Much better CA collaboration occurred in both states after three CAs (MSH, JHU/PCS, and JHPIEGO) came together in 1995, at USAID's urging and after the 1996 management needs assessment in both states, to develop a more coherent program strategy. The concept of PROQUALI flowed from this CA partnership. The partnership was aided by the coincidence that the CA professionals knew each other after many years of working in Brazil and from which a trust had been established. They also agreed that the program was too large for a single CA to execute. The spectre of a short time frame to show results prior to USAID's phase-out also may have contributed to increased levels of institutional cooperation. This strong program initiative became the lead program element in each state. Other CAs, such as Pathfinder and the Population Council, although not part of the core PROQUALI team, contributed valuable complementary components to PROQUALI, such as SISMAC (Pathfinder) and situational analyses (Population Council).

USAID/W Support: Since all of the CAs in the Brazil program are funded from USAID/W Global Bureau agreements, the program depended heavily on the timely actions and Washington-level coordination of the Brazil program backstop in the Global Bureau. A single person played this role throughout the 1992-2000 period, providing an extraordinary degree of continuity and bringing an unusual degree of program knowledge and experience. This is an

ideal situation, especially during a phase-out period. A less knowledgeable and experienced person might not have been as able to help keep the program funded at adequate levels, ensure sufficient CA attention to a country program that could have been placed on a "back burner" in their list of global priorities, and ensure that CA workplans were consistent with the needs of the Brazil program.

Importance of a Product Idea: PROQUALI is an excellent example of a product idea that has quickly become the focus of the total USAID-funded effort in Bahia and Ceará. The three CAs that developed PROQUALI along with their Brazilian counterparts adapted a well-known but limited technical program (AVSC's COPE), added components to meet the needs identified by the 1996 management survey, added a certification component, and chose a very attractive and easily remembered program name. PROQUALI, with its clear focus on quality, has quickly become the jewel in the USAID program and is becoming increasingly well-known beyond Bahia and Ceará.

Prior to PROQUALI, the USAID program did not appear to Brazilian counterparts to have a center or focus. Although USAID and CA staff knew they were working within the context of a USAID/Brazil Strategic Objective, explaining the sum of their efforts as an attempt to achieve results (as measured by USAID program indicators) had no cache with Brazilian counterparts in state governments. To quote a high level Ceará health official, "prior to PROQUALI, I didn't know what the USAID program was trying to achieve."

Continuity of Personnel and Program Strategy: The Brazil program benefited from an unusually high degree of continuity in terms of the personnel involved with the program and in continuity of program strategy.

Personnel: USAID personnel continuity was unusually good for the Phase II period. As noted above, a single person served as the USAID/W Brazil backstop for the full period. Two PHN officers served in Brazil for the first six years, each one working alongside the Foreign Service national (FSN) family planning officer who served in USAID/Brazil for the full eight years. During the final two years of the period, when the Mission had no Direct-Hire PHN officer on the staff, the FSN asked for and received support from the very experienced USAID/W backstop officer. CA personnel working in Brazil, both American and Brazilian, also maintained a remarkable consistency, even though some changed employers during the period.

Strategy: Both of the USAID/Brazil directors who arrived at post during this strategy period resisted the urge to make major strategic changes upon their arrival. All changes made were carried out within the context of the initially approved strategic plan - e.g., some modest changes were made based on the results of the mid-term evaluation in 1995.

In sum, the Brazil model is a valuable model for other phase-out family planning programs. Key lessons learned are: the need for a program idea, the need to establish an effective lead CA relationship between CAs, and the great value of staff and strategic continuity.

ANNEX D: PERSONS INTERVIEWED

USAID/Washington
Ellen Starbird
Jennifer Adams
Rebecca Cohn

USAID/Brazil
Janice Weber
Lawrence Odle
Malu Lins
Cristina Raposa
Nena Lentini
Gisela Ventocilla
Angela Berry

Ministry of Health/Brazil
Raldo Bonifacio Costa Filho
Fabio Moherdau
Katia Souto
Suely Andrade
Heloisa Machado de Souza
Regina Viola

UNICEF
Reiko Niimi

UNFPA
Katia Moreno
Jaime Rojas

JHPIEGO
Sandra Buffington
Deborah Bossemeyer
Edgar Necochea

JHU/PCS
Alice Payne-Merritt
Robert Ainslie
Rosa Said

World Bank
Hernan Montenegro
John Garrison

Management Science for Health (MSH)
Amelia Kaufman
Karen Johnson Lassner
Lia Junqueira Kropsch
Sergio Lins
Maria de Fatima Queiroz

MEASURE EVALUATION
Fannie Fonseca Becker

Pathfinder
Jose de Codes
Christina Barros Kramer
Michael Jonas

The Population Council
Juan Diaz
Loren Galvao

Population Reference Bureau (PRB)
Cindi Cisek
Julia Beamish

SESA-CEARÁ
Anastacio de Queiroz
Francisco Holanda
Jocileide Sales Campos
Escolastica Moura
Rosileia Alves Nogueira
Maria Regina de Freitas

CEARÁ
Maria Hermenegilda da Silva
Silvia Bomfim Hyppolito
Dilene Mafalda Idenfonso da Silveira

SALVADOR MUNICIPAL SECRETARIAT OF HEALTH
Aldely Rocha Dias
Ana Luiza Pinto
Conceicao Gouveia
Ducelina Anjos do Carmo
Suelena Magalhaes Gomes

SESAB/SUDESC
Joselita Nunes Macedo

Rio Grande do Norte
Albanita Leite Soares de Macedo

SESAB/CRESAR
Balbina Lemos Pessoa
Lydia Silva
Eugenia Sampaio
Albertina Matos
Eliana Melo Abreu
Albertina Rabelo Reis
Ana Luiza Moura Fontes
Sandra Mara Brandao Luna
Simone Borges Machado
Veronica Reis
Virginia Falcao
Maria Jussara Pitanga

BEMFAM
Anibal Viana Sampaio
Elizabeth Ferraz
Ney Francisco Pinto Costa
Marcelo Mendonca
Gilvani Pereira Grangeiro

CEPEO
Eduardo de Azevedo R. Brandao
Elizabeth Marie Slavick

CFEMEA
Guacira Cesar de Oliveira
Almira Correia de Caldas Rodrigues
Malo Simoes Lopes

Commercial Market Strategies (CMS)
Robert Bonardi

Federal University of Brasilia
David Fleischer

Instituto Sociedade, Populacao e Natureza (ISPN)
Don Sawyer

Centro Espirita Adolfo Bezarra de Menezes, Sobradinho, DF
Heloisa Helena Silveira

Comunicacao e Cultura, Fortaleza, Ceará
Daniel Raviolo

GRUPO PESACRE, Acre
Richard Cain

Specialist in Sex Education, Salvador, Bahia
Ricardo Cavalcanti